DEPT.- 65

JOB.- 14

REEL.- 33

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

CITY HALL

BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MT ROP[illegible]ED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF _____ BUREAU _____

_____ CREATED FROM THE NORMAL OPERATIONS OF THE _____ AND THAT THE RETENTION PERIOD AS PROPOSED IS NECESSARY FOR COMPLETION OF THE _____ AND THAT

THE MICROFILMING OF THE RECORDS AS SPECIFIED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. _____ IS APPROVED BY THE RECORDS OFFICER IN ACCORDANCE WITH ORDINANCE NO. 105[illegible] APPROVED BY THE MAYOR ON JUNE 4, 1954.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer
Room 402, City Hall, Baltimore 2, Md

Record Identification

1 TITLE: Certificates of Death

2 Form No. if available

3 Type - records, paper, etc: Bound Book

4 Dates

5 Degree of Restriction, if any

6 Size of Records: 8½" x 5"

7 Number of Linear Inches: One (1)

8 Authorization Requested (Check only one (1) of the applicable items)

A [ ] Establish retention period for records which are accumulating daily

B [ ] Dispose of present accumulation and no additional accumulation to be anticipated

C [ ]

D [X] Microfilm and retain for the length of time as shown in item 9 below

9 Recommended Retention Period

a In Dept: 12 yrs.

b In Storage Center: Micro. Perm.

c Total: 12 yrs. and Micro. Perm.

10 Equipment and space freed

11 In your opinion does this record have any historical significance? YES [ ] NO [X]

12 DESCRIPTION OF RECORD (describe accurately and show recommended retention period)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E Tarlov M D, Commissioner of Health — 9/28/62 Date

Recommendations of Records Management Officer

13 Recommended Retention Period

a In Dept: 12 yrs.

b In Storage Center: Microfilm Permanent

c Total: 12 yrs. and Microfilm Permanent

14 Disposal Method

A [ ] To be sold as scrap or waste paper

B [X] To be burned or shredded

C [ ] Historical file to be transferred to Dept of Legislative Reference

REMARKS:

C Price — 9/28/62
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO RECORDS MANAGEMENT OFFICER
ROOM 402, CITY HALL, BALTIMORE 2, MD

1 APPROVED CITY AUDITOR

2 APPROVED CITY SOLICITOR

3 APPROVED CITY COMPTROLLER

4 APPROVED CITY TREASURER

5 APPROVED DIRECTOR DEPT OF PUBLIC WORKS

6 APPROVED DIRECTOR OF THE MUNICIPAL MUSEUM

7 APPROVED DIRECTOR DEPT OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

5741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65741

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address: Leader and Williams

(c) Hospital or institution: 524 Eutaw Apartments

(d) Length of stay in hospital or institution: yrs. mos. or days

(e) Length of stay in Baltimore: yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. County: [illegible]

City or town: [illegible]

(b) Street address: [illegible] Inside city limits?

(c) Citizen of foreign country? Yes or No

If yes, name country:

3. FULL NAME: Margaret A. Bell

3a. If veteran, name war: 3b. Social Security Account No.

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Lawrence Bell

(c) If married, widowed, or divorced, give age years

7. Birth date of deceased: MAY 7 1893

8. AGE: Years 45 Months 3 Days 2 If less than one day, hrs. or min.

9. Birthplace: BALTIMORE

(Town or county, if in U.S.A.; state or foreign country)

10. Usual Occupation: AT HOME

11. Industry or business:

12. Name:

13. Birthplace:

14. Maiden name:

15. Birthplace:

16. (a) Informant: RESIDENCE (b) Address: 1403 MADISON AVENUE

17. (a) BURIAL (Burial, cremation, or removal) Date thereof: JAN 1st 1945

(b) Cemetery or crematory: NEW CATHEDRAL

Location: 801 FREDERICK RD.

18. (a) Funeral director: THE DIPPEL BROTHERS

(b) Address: 200 E. LANVALE ST.

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN 1st 1945

21. I saw [illegible] deceased on [illegible] and last saw [illegible]

Immediate cause of death: (a) CARDIAC FAILURE

Due to: (b) CORONARY OCCLUSION AND INFARCTION OF MYOCARDIUM

Due to: (c)

Due to: (d)

Contributory causes:

Operation:

Date of operation:

Major findings of operation:

Autopsy: NO

22. If death was due to external causes (violence), fill in the following:

(a) Nature of injury:

(b) Date of occurrence: at M.

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, or industrial place, in public place?

(e) Manner of injury:

(f) Signature:

Duration

PHYSICIAN

5742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs. mos. or days 23 Yrs.

2. (a) FULL NAME

3. (b) If veteran, name war

4. Sex: Female | 5. Color or race: White | Single, married, widowed or divorced: Widow

6. (a) Name of husband or wife: Thomas Kelly
(b) If wife, give age

7. Birth date of deceased: mo., day, yr.: April 8, 189-

8. AGE: Years: 58 | Months: 4 | Days: 0

9. Birthplace: Baltimore, Maryland

10. Usual Occupation: None
11. Industry or business:

12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16. (a) Informant
(b) Address: 1918 Eutaw Place

17. (a) Burial
(b) Date of
(c) Cemetery or crematory
Location:

18. (a) Funeral director
(b) Address: 803 W. Calvert Street

DEC 10 1948
(Date of registration)

VS 191

USUAL RESIDENCE OF DECEASED:
State: Md.
City or town: Balto.,
Street No.: 1918 Eutaw Place

MEDICAL CERTIFICATION

20. DATE OF DEATH: April, 1948

21. I certify that I attended the deceased from

Inspection & Inquiry

I last saw the deceased alive on

and that death occurred on the date stated above, at

The principal cause of death was as follows:

IMMEDIATE CAUSE OF DEATH: Myocarditis

Duration

M.D.

5743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 5743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern & Wilkens ave
(c) Hospital or institution St. Agnes Hospital.

(d) Length of stay in hospital or institution, if non-resident: hrs., days, mos., or yrs. Life 20 yrs

(e) Length of stay in Baltimore City, if non-resident: hrs., days, mos., or yrs. Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(d) Street address 2512 Eastern Ave.
(e) Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME Mary E. Woodland.
(b) If veteran, name war Social Security Account No.

4. Sex F. | 5. Color or race W. | 6. (a) Single, married, widowed or divorced M.

6. (b) Name of husband or wife John W. Woodland.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1888

8. AGE: Years 60 Months 0 Days 26 (If less than one day) hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Home maker
11. Industry or business None

12. Name Joseph Figuetta
13. Birthplace Italy

14. Maiden Name Unknown
15. Birthplace Germany

16. (a) Informant Husband
(b) Address 2512 Eastern Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11-48.
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore Md

18. (a) Funeral director Charles J. Schaub
(b) Address 3512 Frederick Ave.

19. (a) Date received Aug 10 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1948 1.20 A.M.

21. I hereby certify that I attended deceased from to that I last saw deceased alive on and that death occurred at the hour stated above.

Immediate cause of death (a) Cerebral Hemorrhage
Due to
Due to
Other conditions

Operative

Date of operation
Major findings of operation

of autopsy

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (Give street address or location, town, county, state)
(d) Did injury occur while at work?
(e) Means of injury
(f) Signature
Address

665744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

665744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St and Monument Ave
(c) Hospital or institution
Maryland General Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days 1 day
(e) Length of stay in Baltimore yrs., mos., or days 7 days

2. USUAL RESIDENCE OF DECEASED:
State Md
Caenter
Odenton
Citizen of what foreign country No
If yes, how long in U.S.

3. (a) FULL NAME Roberta Emma

3. (b) If veteran, name war
3. (c) Social Security Account No

4. Sex Female
5. Color or race White
6. Single, married, widowed or divorced Married

6. (a) Name of husband or wife Harry M. Chaney
(b) If widowed, give name

7. Birth date of deceased August 29, 1901

8. AGE Years 47 Months 11 Days 18 If less than one day

9. Birthplace Strasburg, Virginia
(Town, county and state)

10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name John M. Mitchell
13. Birthplace Strasburg Va

MOTHER
14. Maiden Name Ida Palmer
15. Birthplace Strasburg Va

16. (a) Informant Harry M Chaney
(b) Address Odenton, Md

17. (a) Burial (Burial, cremation or removal)
(b) Date thereof Aug 12, 1948
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18. (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md

19. (a) AUG 10 1948 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948

21. I HEREBY CERTIFY, That I attended the deceased from August 3 1948, that I last saw the deceased alive on August 9 1948, that death occurred on the date stated above, at 7:45 A.M.

Immediate cause Respiratory failure — duration 7 days
(a)
Due to (b) Intracranial hemorrhage — duration 7 days
Due to (c) Hypertensive cardiovascular disease — duration 5 years
(d)

Contributory Chronic pneumonia — duration 5 days

Operation Date of operation
Major findings of operation

Was autopsy performed?
Were findings considered in determining cause of death?

(a) Address
(b) Date of occurrence at M
(Accident, suicide or homicide?)
Describe how injury occurred, and name of public road or private property where it occurred
Manner of injury

(c) Signature
Address

PHYSICIAN

VS 1-52

665745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665745

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution Foot of Bond Street

USUAL RESIDENCE OF DECEASED
[illegible] 3-1 [illegible] E. Bond Street

(d) Length of stay in hospital or inst. yrs, mos, or days
(e) Length of stay in Baltimore yrs mos, or

2 (a) FULL NAME [illegible] F. [illegible]

3 (b) If veteran, name war [illegible] Account No.
World War 2

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
(c) If widow, give age years

7 Birth date of deceased mo, day, yr Sept. 12, 1906

8 AGE: Years 41 | Months 42 | Days | If under one day

9 Birthplace Philadelphia, Pa.
Town or County, State or Country

10 Usual Occupation
11 Industry or business

12 Name Harry McCaulley
13 Birthplace Pennsylvania
14 Maiden Name [illegible]
15 Birthplace Pennsylvania

16 (a) Informant Harry McCaulley
(b) Address 1616 Tara St., Linwood, Pa.

17 (a) Removal [illegible] Date thereof [illegible]
(b) Burial, cremation or removal
(c) Cemetery or crematory Parkwood Memorial Park
Location Marcus Hook, Pa.

18 (a) Funeral director Tilp and Heller, Inc.
(b) Address 1501 E. Lombard St., Balto. 24, Md.

19 AUG 17 1948 [signature]
Local registrar

VS 181

MEDICAL CERTIFICATION

20 DATE OF DEATH August 7, 1948

21 I certify that I attended the deceased from [illegible] and last saw [illegible] alive on [illegible] and that death occurred on the date stated above at [illegible] M.

Approximate interval between onset and death [illegible]
Contributory [illegible] autopsy [illegible] accident, suicide or homicide [illegible] Death verified by [illegible]

IMMEDIATE CAUSE OF DEATH [illegible]

[illegible] Bond Street

[illegible] Penna. R.R. [illegible]

[illegible] No.

[illegible] M.D.

665746
AB-121799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or if not in hospital, number of days 5days
(e) Length of stay in Baltimore if not in Baltimore, number of years -Lifve- 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(d) Street address 1919 E. Pratt St.
(e) Citizen of what country? Poland (f) How long in United States of America? (If not)

3. FULL NAME Wladyslew Walter Goralski
(b) If veteran, write WAR

4. Sex M 5. Color or race W 6. If married, widowed, or divorced Married
(a) Name of husband or wife Mary Goralski
(b) If married, widowed, or divorced, age of husband or wife 59 years

7. Birth date of deceased 1-1-1 1882
8. AGE Years 66 Months Days If less than one day, hours or minutes

9. Birthplace Poland

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Goralski
13. Birthplace Poland

MOTHER
14. Maiden Name Bogumila Pietrowski
15. Birthplace Poland

16. (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17. (a) Burial, cremation, or removal (b) Date buried Aug 11 1948
(c) Cemetery or crematory Holy Rosary
Location Baltimore County
18. (a) Funeral director John J. Kelley
(b) Address 451 N. Chester Street
19. (a) AUG 10 1948 (Date received by Registrar) (b) [illegible]

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH (month, day, year) Aug. 8 48 3.10 P.M.
21. I hereby certify that I attended the deceased from 8-3-48 to 8-8-48, that I last saw the deceased alive on 8-8-46, that death occurred on the date stated above, at the hour stated.

Immediate cause (a) Uremia
Antecedent causes (b) Arteriosclerotic Cardio Vascular disease
(c)
(d)
Other conditions Arteriosclerotic Gangrene - rt leg
Date of operation None
Major findings of operation
Was there an autopsy?
If death was due to external causes (violence) fill in the following:
Accident, suicide or homicide?
Date of occurrence at M.
Where did injury occur?
Did injury occur in or about home, farm, industrial place, in public place?
(Specify which)
Manner of injury
How injury occurred

PHYSICIAN
I saw the deceased from to
Date signed

Signature Norman J. Cole, M.D.
Address 4940 Eastern Ave. Date signed 8/10/48

(65747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. (65747

BC = 12671

1. PLACE OF DEATH.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution
Provident Hospital

(d) Length of stay in hospital or institution: yrs., mos., or days
(e) Length of stay in Baltimore: yrs., mos., days

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security No.

No

4. Sex F | 5. Color or race C | 6. If single, married, widowed or divorced

6 (b) Name of husband or wife

6 (c) If married, widowed or divorced, age

7. Birth date of deceased mo., day, yr.

8. AGE: Years | Months | Days

If less than 1 day, hrs. or min.

9. Birthplace Balto. Md.
State or foreign country

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernice [illegible]
13. Birthplace North Carolina

MOTHER
14. Maiden Name [illegible]
15. Birthplace Baltimore, Md.

16 (a) Informant Nelson Williams
(b) Address 541 Telford St.

17 (a) Burial
Burial, cremation or removal
(b) Date of burial Aug 6-41
(c) Cemetery or crematory Loudon Park
Location Baltimore and [illegible]

18 (a) Funeral director Elroy Dickson
(b) Address 1940 Blanton Ave
Baltimore, Md.

19 (a) [illegible]
(b) [illegible]

VS 15

2. USUAL RESIDENCE OF DECEASED

19-2

No. 0 Fort [illegible]

If outside city limits

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 8 [illegible] 10 P.M.

21. I certify that I last attended deceased from [illegible] to [illegible] and that the cause of death was Injury

Autopsy [illegible]

Signed Autopsy [illegible] certificate [illegible] deceased came to [illegible] and the cause of death was [illegible] as stated above. Injuries resulted from [illegible] accident. Manner of injury was [illegible]

IMMEDIATE CAUSE OF DEATH [illegible]

[illegible]

22. If accident, suicide or homicide [illegible]

Date [illegible] P.M.

Where [illegible]

[illegible]

Witness [illegible]

Signature [illegible] M.D.

Date signed [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66748

66748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 W. West St.
(c) Hospital or institution

2. USUAL RESIDENCE OF DECEASED
State Md.
City or town Baltimore
Street No. 136 W. West Street
Inside City Limits? (Yes or No)
If yes, ward or district

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Mattie Brogden (Bradgen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex F
5. Color or race C
6. Single, married, widowed, or divorced Married

20. DATE OF DEATH August 9, 1948 at 4:55 M

6 (b) Name of husband or wife Charles Brogden

6 (c) If alive, give age

21. I certify that I was in attendance on the deceased from Inspection to August 9, 1948 that I last saw deceased alive on August 9, 1948 and that death occurred at the hour stated above. An autopsy was/was not performed. In my opinion death was caused by the conditions and causes stated below. Accident/Suicide/Homicide. The above conditions and causes of death were:

7. Birth date of deceased (mo., day, yr.) July 11, 1908

8. AGE: Yrs. 40 Months Days

IMMEDIATE CAUSE OF DEATH

9. Birthplace Maryland (Town or city and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Parker
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Matthews
15. Birthplace Maryland

16. (a) Informant Ella Phillips (S)
(b) Address 708 Hanover Street

17. (a) Burial, cremation, or removal
(b) Cemetery or crematory
Location

18. (a) Funeral director
(b) Address

19. Filed AUG 10 1948

M.D.

VS 15

BALTIMORE CITY HEALTH DEPARTMENT

66749

Registered No.

065749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

065749
Registered No.

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hadwood & Preston St
(c) Hospital or institution:
University Maryland
(d) Length of stay in hospital or institution, years, months, or days 1 Day
(e) Length of stay in Baltimore, years, months, or days 2 Mos.

2 USUAL RESIDENCE OF DECEASED
(a) State Md County
(b) City or town Baltimore
(c) Street No. 1 N Pearl St
(d) Citizen of [illegible] Yes or No
If yes, name country

3 (a) FULL NAME Albert
(b) If veteran, name war
(c) Social Security Account No.

4. Sex male | 5. Color or race white | 6. If married, widowed, or divorced divorced

6 (a) Name of husband or wife
(b) If alive, give age

7. Date of death (mo., day, yr.) July 21, 1948
8. AGE: Years 56? | Months | Days | If less than one day, hr. | min.

9. Birthplace West Virginia (Town, city, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Hezekiah O. Gwinn
13. Birthplace West Virginia

MOTHER
14. Maiden Name
15. Birthplace West Virginia

16. (a) Informant Mrs. Dodd
(b) Address Webster Springs W. Va

17. (a) Removal (Burial, cremation, or removal)
(b) Date Buried Aug 19/48

(c) Cemetery or crematory
Location Webster Springs, W.Va

18. (a) Funeral director Sherry W. Wright
Address 1101 Eutaw Place

Filed AUG 20 1948
(Registrar)

VH 161

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1948 at 12:40 AM

21. I certify that I took charge of the remains of the above-named person on [illegible] from the residence obtained by said Autopsy [illegible] and that said deceased came to death on the day stated above, and death in my opinion resulted from [illegible] accident, suicide, or homicide [illegible] and that the cause of death were

IMMEDIATE CAUSE OF DEATH
Uremia due to Pneumonia

Due to

Other conditions

22. If accident, homicide, suicide, or [illegible] state when, where, and how injury occurred, and whether [illegible] death

(a) Date of [illegible] M
(b) Address
Did [illegible] perform public [illegible]
(d) Medical examiner
(e) Signature M.D
Date signed Aug 19, 1948

VS 161

65750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65750

1. PLACE OF DEATH

a. Baltimore City, Maryland

b. Street address 1231 Hanover St

c. Hospital or institution:

d. Length of stay in hospital or inst., yrs., mos., or days

e. Length of stay in Baltimore, yrs., mos., or days 10 mo

2. USUAL RESIDENCE OF DECEASED:

State Md. County

City or town Balto

(If outside city or town limits write RURAL and give town

a. Street No. 1231 Hanover St

(If rural give location)

f. Citizen of foreign country? Yes or No

If yes, name country

3. a) FULL NAME Peter J. Williams

b) If veteran, name war No

c) Social Security Account No

4. Sex Male

5. Color or race White

6. a) Single, married, wid., wd., or divorced Widower

b) Name of husband or wife Laura A. Williams

c) If married, give age

7. Birth date of deceased mo. day yr. March 11 1870

8. AGE: Years 74 Months 10 Days If less than one day hrs. min.

9. Birthplace Queenstown, Md.

10. Usual Occupation Retired Painter

11. Industry or business

12. Name Peter Jr. Williams

13. Birthplace Md.

14. Maiden Name

15. Birthplace Md.

16. a) Informant Mrs. L. A. Williams

b) Address 1231 Hanover St

17. a) Burial, cremation, or removal Date thereof

b) Cemetery or crematory

Location

18. a) Funeral director

b) Address

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9, 1945, at 10 A.M.

I certify that I last attended deceased from May 24, 45 to Aug 9 1945

and that I last saw him alive on Aug. 9 1945

Immediate cause of death

a. Coronary Thrombosis

Due to

Other conditions

Date of operation

Major findings of operation

Duration

PHYSICIAN

Underline the name to which death should be charged (state fully)

of autopsy

Were there any other significant conditions contributing to death but not related to the immediate cause given?

If accident, violence or homicide:

b) Date of occurrence at M

Where did injury occur? (Specify City or County) State

Did injury occur in or about home, on farm, in industrial place or in public place?

Specify activity at time of injury

Manner of injury

Source of information

Signature Rev. Jno. J. Smith

Address 12 Randall St Date signed 8/10/45

VS 150

66571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 66571

1. PLACE OF DEATH:
a) Baltimore City, Maryland
b. Street address 2075 Rockrose Avenue
c. Hospital or institution
Ardleigh Nursing Home
d. Length of stay in hospital or institution yrs. mos. or days
e. Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
a. State
b. County
c. City or town Baltimore
d. Street address 1340 Beryl Avenue
e. Length of stay at this residence yrs. mos. or days

3. (a) FULL NAME Louis Joseph Scull, Sr.
3. (b) If veteran, name war
3. (c) Social Security Account No.

4. Sex male
5. Color or race white
6. If single, married, widowed or divorced widowed
7. (a) Name of husband or wife Mary (nee Blazek)
(b) If deceased, give age years
8. Birth date of deceased (Month, day, year) August 20, 1880
AGE: Years 68 Months Days If less than one day
9. Birthplace Czechoslovakia (State or country or foreign country)
10. Usual Occupation retiree
11. Industry or business

FATHER
12. Name John Scull
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16. (a) Informant Mrs. Clara Joy - daughter
(b) Address 2640 Beryl Avenue

17. (a) Burial Date of burial 8/ 2, 48
(b) Cremation, entombment or other
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18. (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19. (a) AUG 10 1948 Registrar
(b) Date received by registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1948 at 6 50 A.M.

21. I attended the deceased from July 23 1948 to August 9 1948
I last saw the deceased on August 9 1948

Immediate cause of death — Duration

Disease Metastatic carcinoma

Due to Gastric neoplasm

Due to Auricular fibrillation

Other significant conditions contributing to death but not related to terminal disease sequence Cardiac decompensation

Date of operation

Major findings of operation

PHYSICIAN

Address 3631 Juneway Rd. Aug 10 48

16571-62
IB-12 1099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 16571-62

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (or location) 4940 Eastern Ave.
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or institution, years, months or days 30 days
(e) Length of stay in Baltimore, years, months or days Life

2. USUAL RESIDENCE OF DECEASED
State Md. County Baltimore
City or town Essex
Street address 311 Stillwater Ave.
If outside city or county, give town or county

3. a FULL NAME Joseph John Weinhold
b If veteran, give war Social Security Account No.

4. Sex M | 5. Color or race W | Single, married, widowed or divorced Married

6. a Name of husband or wife Anna Rupp Weinhold
If married, widowed or divorced

7. Birth date of deceased (Month, day, and year) Feb. 11- 1882

8. AGE Years 66 | Months | Days | If less than one day, hours or minutes

9. Birthplace Md. Baltimore
(City or county) (State or foreign country)

10. Usual Occupation Bricklayer
11. Industry or business Novak Realty Co.

FATHER
12. Name John Henry Weinhold
13. Birthplace ? Baltimore, Md.

MOTHER
14. Maiden Name Anne Pocot
15. Birthplace Md.

16. a Informant Mrs. Marie Rabb - daughter
b Address 457 Drew Street, Balto - 24 - Md.

17. a Burial, cremation, or removal Burial b Date thereof 8/13/48
c Cemetery or crematory Sacred Heart
Location German Hill Rd.

18. a Funeral director Schimunek Funeral Home, Inc.
b Address 2601-3-5 E. Madison Street

AUG 10 1948 Standing for Nilsen, MD
Date received by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9- 48 at 11A M

21. Duration of: Aug. 8- 48 to Aug. 9- 48
Last illness Im Aug. 7- 48
Injury: Date of injury Duration of injury

Cause of death
(a) Myocardiosclerosis terminal 1 day
(b)
(c)
(d)

PHYSICIAN

Date of operation
Major findings of operation

Autopsy

Was there an autopsy?
Were findings considered in determining cause of death?

20. Date of occurrence at M
Where did injury occur? (Specify whether in home, factory, street, farm, or other public place)
How did injury occur?

Manner of injury
Signature M. J. Nelson
Address Date signed 8/9/48

VS 5

5753

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 665753

CERTIFICATE OF DEATH 1940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern & Dellcastle
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(Outside city limits, write R.F.D. and give location)
(d) Street No. 3[illegible] Eastern Ave
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Benjamin Dove
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]
8. AGE: Years 56 Months 2 Days If less than one day hr. min.
9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Driller Painter
11. Industry or business Paint Store

FATHER
12. Name B. Franklin Dove
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Anne Hughes
15. Birthplace Maryland

16 (a) Informant Mrs Benjamin Dove
(b) Address 18 S. [illegible] Ave Catonsville Md

17 (a) [illegible] (b) Date thereof 8/13/40
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) [illegible] (b) [illegible]
Registrar

MEDICAL CERTIFICATION

20 DATE OF DEATH [illegible] 1940, 10:30 A.M.

21. I certify that I attended the deceased from [illegible] to [illegible] that I last saw [illegible] alive on [illegible] and that death occurred on the date stated above, at [illegible] M.

Immediate cause of death Coronary Occlusion
Heart Failure
Due to Coronary sclerosis, Multiple embolic
Due to Pneumonia Bilateral
Other Conditions Contributory

Erratum

Date of operation June 21, 1940
Major findings of operation: Fibrosis adhesions
If autopsy: no

PHYSICIAN
[illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Specify which
(e) Means of injury

23. Signature Frank [illegible] M.D.
Address St Agnes Hospital Date signed 8-14-40
Baltimore Md

VS 150

5751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19--
(c) Hospital or institution:
Johnston Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
State Md County
(f) City or town Baltimore
(d) Street No. 1325 W. Fayette St.
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John Albert WESTLAKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE:	Years	Months	Days	If less than one day: hr.	min.
	57				

9. Birthplace .....
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month, day, year)
(c) Cemetery or crematory .....
Location: .....

18 (a) Funeral director .....
(b) Address .....

19 (c) AUG 10 1948 .....
(Date rec'd by registrar) Registrar

AUG 10 1948
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 7.43 P M

21. I certify that I took charge of the remains described above and an Autopsy thereon and from the records and Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes / accident / suicide / homicide / undetermined / and the principal causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Fatty degeneration of liver.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was present, state cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur in or about home, factory, public place? ..... What was deceased doing?
(d) Means of injury .....

23. Signature ..... M.D.
Date signed 7/21/48

VS 151

5750

BALTIMORE CITY HEALTH DEPARTMENT

665755

5755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 108

Registered No. G65755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. County
(c) City or town Glen Burnie,
(d) Street No.
(e) Citizen of foreign country? If yes, name country

3 (a) FULL NAME Baby Boy Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 2 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day)

(c) Cemetery or crematory

Location Baltimore Medical School AUG 10 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 10 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1948 at 11:05 M.

21. I certify that I took charge of the remains (last bed absence) held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia, left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was present (or was) the cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, in factory, on street, in public place? White (Negro)
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 8/3/48

VS 151

56 BALTIMORE CITY HEALTH DEPARTMENT G65756

B121752 CERTIFICATE OF DEATH 12 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life (51 yrs)

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
If outside city or town limits, write RAL and name of town
d Street No. 1028 Denver st.
e Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elmer Leitch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Margaret Stansbury
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Oct. 12, 1896

8. AGE: Years 51 | Months 9 | Days 20 | If less than one day hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Roofer - Painter
11. Industry or business Own Business

FATHER
12. Name Ernest Leitch
13. Birthplace Md

MOTHER
14. Maiden Name Alice Coursey
15. Birthplace Md

16 (a) Informant Records - Balto. City Hospitals
(b) Address 4940 EasternAve.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St Paul st.

19 AUG 11 1948 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 48 at 8:46 A.M. M

21. I certify that I attended deceased from 8-2- 48 to 8-10 48
and last saw him on 8-10 48
Immediate cause of death Pulmonary tuberculosis
Due to
Due to
Other Conditions
Duration 5-10 yr
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
In giving the cause from which death is to be charged state especially

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place, or while at work?
(e) Manner of injury
23. Signature Gayle Burton
Address Baltimore City Hospitals Date signed 8/10/48

VS 199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. GE 5757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Eutaw Place #7
(c) Hospital or institution Sinai Hospital 14 days
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
Street 2023 Eutaw Pl
City Baltimore
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELROSE BOTSFORD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W.
6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Harold C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1902

8. AGE: Years 45 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Chicago Ill
(Town, county, and state)

10. Usual Occupation Telephone operator
11. Industry or business

12. Name Florence M Marshall
13. Birthplace Ill
14. Maiden name Mrs Ethel A Bennett
15. Birthplace Ill

16 (a) Informant Mrs Ethel Bennett
(b) Address 2023 Eutaw Place Baltimore Md

17 (a) Burial, cremation, removal (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Green mount Cem
Location Balto
18 (a) Funeral director Wm Cole Sons
(b) Address 1207 N Howard St

19 Filed AUG 11 1945 (b) Signature of Registrar Wm H Williamson M.D. Registrar

VS 15M

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1945 at 7.55 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/2 1945 to 8/6 1945 and that I last saw h alive on 8/6 1945

IMMEDIATE CAUSE
Immediate cause of death Overwhelming SBC
(Multiply spread)
ANTECEDENT
Due to Hem Meningoencephalitis
INTERVAL BETWEEN ONSET AND DEATH
Due to adrenal, renal, etc. involvement
Other Conditions (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy multiply SBC

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H Williamson
Address Sinai Hospital Baltimore Md Date signed 8/8/45

5758

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46 J

Registered No. G65758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Enroute in ambulance
(b) Street address to University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore: (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Balto
(c) City or town Fullerton Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Klein Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME Watson Grymes

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-9293

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Pharmacist

11. Industry or business

FATHER
12. Name John S. Watson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Tates
15. Birthplace Va.

16 (a) Informant Mrs. Watson Grymes
(b) Address Klein Ave., Fullerton, Md.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 8, 13 48 (month) (day) (year)

(c) Cemetery or crematory Campbell Memorial
Location Kirkwood, Lancaster Co Pa

18 (a) Funeral director Lancaster Funeral Home
(b) Address 750 [illegible] Ave Lancaster Pa

AUG 11 1948
(Date rec'd by registrar) (b) Registrar Baltimore, Md.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 4:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 6-11 1948 to 8-14 1948, and that I last saw h[illegible] alive on 8-12 1948.

Immediate cause of death: Ruptured [illegible]
Due to Hemorrhagic shock
Due to Exploration
Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Exploration
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, or public place? (While at work)
(d) Means of injury

23. Signature Robert E Hamilton M.D.
Address Fullerton Md. Date signed 8-10

3753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G65759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antone Chudy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Steel Co.

FATHER
12. Name Peter Chudy
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Frances Chudy
(b) Address 124 S Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Catholic Cem
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 (a) AUG 11 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by and Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Coronary Heart Disease

Other Conditions Active tuberculosis generalized
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert F Menaker M.D.
Medical Examiner
Date signed 8-9-48

VIII 191

5760
AB-103562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G65760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Dovers St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Margaret Kilper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1875

8. AGE: Years 73 | Months | Days | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Frederick Kilper
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 12 '48 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location Edmondson Ave - Longwood

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

AUG 11 1948 (b) Wright & Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10- 19 48 at 6.20 AM

21. I certify that deceased was last seen by me on the date above stated, that I attended deceased from 8-7- 19 46 to 8-10- 19 48, and that I last saw deceased alive on 8-10-48

Immediate cause of death	Duration
Cerebral vascular accident	24 hours
Due to	
Due to	
Other Conditions Hypertensive Heart disease	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify type of place)
(e) Means of injury

23. Signature John Reichold
Address Balt. City Hosp. Date signed 8/10/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G65761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Harris Donn robert harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1948

8. AGE: Years | Months | Days 2½ | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

12. Name Donald Joseph Harris

13. Birthplace Baltimore, Md.

14. Maiden Name Rebecca Louise Muller

15. Birthplace Statesville N. Carolina

16 (a) Informant Mrs. Donald J. Harris

(b) Address 3020 Wayne Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director E. W. Pennington

(b) Address 4510 Liberty Heights Ave.

19 AUG 11 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948, at 10 08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8, 1948. to Aug. 10, 1948. and that I last saw him alive on Aug. 10, 1948.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Report will be sent later

over

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature William G. Spencer Jr. M.D.

Address Hosp. for Women of Md. Date signed 8-11-48

65762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. 65762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.D. or R.F.D., and give town)
(d) Street No. 1208 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. F. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9342

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Nora G. Wilson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) September 30, 1887

8. AGE: Years	Months	Days	If less than one day
60 6t	10	10	hr. min.

9. Birthplace Turner Station, Baltimore Co., Md
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name John Thomas Wilson
13. Birthplace Maryland

MOTHER
14. Maiden Name Lottie M. Proctor
15. Birthplace Maryland

16 (a) Informant Mrs. John T. Wilson
(b) Address 3939 Flowerton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1003 W. Baltimore St.

AUG 11 1948 [illegible]
(Date received by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 8 A. M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
coronary heart disease

Due to

Other Conditions

(Include pertinent complications and duration between onset and death)

22. If an external cause was primary or secondary (or suspected) cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Specify
(d) Means of injury

23. Signature C. J. Edwards M.D.
Medical Examiner.
Date signed 8/10/48

VS 151

5763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1632

Registered No. G65763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 St. Paul St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Justina Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Seperated

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 19, 1911

8. AGE: Years	Months	Days	If less than one day
37	4	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Typist

11. Industry or business

12. Name Edward Wagner

13. Birthplace Balto.

14. Maiden Name Justina Habel

15. Birthplace Balto.

16 (a) Informant Mrs. J. Holl (sister)

(b) Address 613 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/1948 (month, day, year)

(c) Cemetery or crematory Sacred Heart Cem. Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 South Wolfe Street

AUG 11 1948 (Date rec'd by Registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948, at 1.20 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate poisoning

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-4-48 at approx. 2.30 PM.

(b) Where did injury occur? 712 St. Paul St.

(c) Did injury occur at home, or farm, industrial place, in public place? home While at work? no

(d) Means of injury Ingestion of sleeping pills

23. Signature [illegible] M.D. (Medical Examiner.)

Date signed 8/9/48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 665769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fourpoint & 1
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL or name town)
(d) Street No. 5812 Bland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Shulman

3 (b) If veteran, name war: 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business
12. Name of father Jacob Russia
13. Birthplace
14. Maiden Name of mother Lilly Russia
15. Birthplace
16 (a) Informant Mr. Ike Meyer
(b) Address 2210 Bland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-48 (month) (day) (year)
(c) Cemetery or crematory Shaare Tefiloh
Location Liberty Road
18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eastern Ave
19 (a) AUG 11 1948 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948 at 11:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/6 1948 to 8/10 1948, and that I last saw h alive on 8/10 1948.

Immediate cause of death: Cerebrovascular Hemorrhage
Due to: Arteriosclerosis & Hypertension
Due to:
Other Conditions: Right leuc
Bile Pneumonia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy Sinai

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury
23. Signature Bernard Gibbs
Address Sinai Hosp. Date signed 8/10/48

VS 150

83a

5765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 665765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years 17 Months Days If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Lee
13. Birthplace Waynesboro Md.

MOTHER
14. Maiden Name Leonie Brown
15. Birthplace Hamons, Md.

16. (a) Informant Mr. & Mrs. Robert Lee.
(b) Address 507 N. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month, day, year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 324 N. Schroeder St.

AUG 11 1948 (Date rec'd by registrar)

(b) [illegible]

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948, 1:00 M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions

Include pregnancy within three months of death.

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury August 7, 1948 M.
(b) Where did injury occur? Hammond Ferry Rd.
(c) Did injury occur at home, on farm, industrial place, in public place B & O. overpass (Specify) No
(d) Means of injury Car went over the overpass

23. Signature [illegible] M.D.
Medical Examiner
Date signed Aug 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 665766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Lyndon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Lyndon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Kell

3 (b) U. S. veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Adelaide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 1868
8. AGE: Years 80 Months 3 Days 18 If less than one day hr. min.
9. Birthplace Alexandria Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer

FATHER
12. Name John Kell
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Alveda Meehan
(b) Address 1219 Lyndon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson + Longwood Sts

18 (a) Funeral director John F Coyne & Son
(b) Address 901-03 Mollison St

19 (a) Aug 11 1948 (Date received by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948 at 7.32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948, to Aug 9 1948, and that I last saw h[illegible] alive on Aug 9 1948.

Immediate cause of death: Myocardiotis Chronic and myocardial degeneration — Duration: 6 mo.
Due to Hypertensive Cardiovascular Renal Arteriosclerosis — 6 yr.
Due to Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr M. D.
Address 1227 Wash. Blvd Date signed 8/10/48

VS 150

5767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G65767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Fawn St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANGELA BERTORELLI

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife late Giovanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15 1870

8. AGE: Years	Months	Days	If less than one day
87	10	24	hr.

9. Birthplace Carrara Prov. Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Paolo Iperoni
13. Birthplace Italy

MOTHER
14. Maiden Name Domenica Bargassi
15 Birthplace Italy

16 (a) Informant Luigi Pizzitolli (Daughter)
(b) Address 1008 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 822 S. High St.

AUG 11 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-48 19 , at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22-48 19 , to 8-8-48 19 , and that I last saw h alive on 8-6-48 19 .

Immediate cause of death Carcinoma of bladder — Duration 10 mos
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 8 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John Gentile, M.D. M D
Address 230 S Conkling St Date signed 8-10-48

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G65768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G65768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. High St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 207 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Frances Citrano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1881

8. AGE: Years 66 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name of father Joseph Citrano

13. Birthplace Italy

14. Maiden Name of mother Concetta Pitarra

15. Birthplace Italy

16 (a) Informant Sarah Cicchitto (Sister)

(b) Address 207 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dellacase

(b) Address 328 S. High St.

19 (a) AUG 1 1948 (Date received by registrar) (b) [illegible]

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1948 to Aug 9 1948 and that I last saw her alive on Aug 9 1948

Immediate cause of death Pulmonary failure — Duration

Due to Chronic Nephritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scaquetti, M. D.

Address 1724 W Lombard St Date signed Aug 10 '48

X

85769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 472 Manse Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Geneva Bussie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Albert | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-05

8. AGE: Years 42 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER
12. Name George Lewis
13. Birthplace
FATHER
14. Maiden Name Elizabeth Harper
15. Birthplace Md. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winder, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St., Baltimore, Md.

19 Date received Aug 9 1949 (Local registrar) Fannie [illegible], Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1949, at 9 08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 8/9 1948 and that I last saw her alive on 8/9 1948.

Immediate cause of death	Duration
Uremia	days
Due to Anuria	days
Due to Subfatthyroid sensitivity	days
Other Conditions Hypertensive cardio-vascular dis. Prostate geriatrics. (Include pregnancy within 3 months of death)	years

Date of operation None
Major findings of operation:
of autopsy: No autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Siggins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

vs 50

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G65770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G65770
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 E. 20th St.
(c) Hospital or institution: 9-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
8 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. 20th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Jane Smith

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James B. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 26, 1862

8. AGE: Years 86 Months 3 Days 14 If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Housewife,
11. Industry or business: at home

FATHER: 12. Name: James Kelly,
13. Birthplace: Ireland,

MOTHER: 14. Maiden Name: Brigid O'Brien,
15. Birthplace: Ireland.

16 (a) Informant: Miss Helen Smith,
(b) Address: 521 E. 20th. St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Baltimore, Md.

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave.

(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 9-20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 to 8/10 1948.
and that I last saw h alive on 8/10 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 6 weeks
Due to: Arteriosclerotic Cardio-Vascular Disease — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William H. Frasier M. D.
Address: 11 East Chase St. Date signed:

VS 180

X

G65771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G65771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison
(c) Hospital or institution: 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Lanier (Jane Lanier)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1893

8. AGE: Years 55 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name of husband Wm Lanier

13. Birthplace Md

14. Maiden Name of wife Wm Lanier

15. Birthplace Md

16 (a) Informant Mrs Lanier

(b) Address 1127 W Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore City

Name of Funeral Director

Address 1300 Pennsylvania Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/ 1948 to 8/10 1948 and that I last saw h[illegible] alive on 8/7 1948

Immediate cause of death: Chronic Cardiovascular Renal disease — Duration: 2 years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. [illegible] M. D.

Address 1300 Washington Ave Date 8/11

X

PS 150

G65772 ✓ G65772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Madeira ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 - Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mullins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: col | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/4/1863

8. AGE: Years 85 | Months 5 | Days 3 | If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name of father Unknown
13. Birthplace of father Unknown

14. Maiden Name of mother Unknown
15. Birthplace of mother Unknown

16 (a) Informant Undertaker Wil Bar Home
(b) Address 1917 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Oberley
(b) Address 1917 Madison Avenue

MEDICAL CERTIFICATION

19. DATE OF DEATH 8/7 1948 at 5:45 P.M.

20. I certify that death occurred on the date above stated, that I attended deceased from 7/15 1948 to 8/7 1948
and that I last saw [illegible] alive on 8/6 1948

Immediate cause of death

	Duration
Uremia Cardiac Hypertension Hypertrophy	2 yrs
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible]

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G65773

G65773

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 733 W HAMBURG ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 733 W. HAMBURG ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN M. SCOTT

3 (b) If veteran, name war –

3 (c) Social Security Account No. 213-01-0499

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife DOROTHY SCOTT

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) NOV-15-1892

8. AGE: Years	Months	Days	If less than one day
55	8	26	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation GLASS WORKER.

11. Industry or business BUCK GLASS Co.

FATHER 12. Name JOHN B SCOTT

13. Birthplace SCOTLAND

MOTHER 14. Maiden Name ALICE McCAEAN

15 Birthplace MARYLAND

16 (a) Informant DOROTHY SCOTT

(b) Address 733 W HAMBURG ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS CEM Location A A Co.

18 (a) Funeral director Bernard E Hartz

(b) Address 121 E WEST ST.

19 (a) (Date received) (Registrar) (b) Registered

VS 150

MEDICAL CERTIFICATION

26. DATE OF DEATH AUG. 11 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1948 to Aug 11 1948 and that I last saw him alive on Aug 11 1948

Immediate cause of death Carcinoma, Lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1948

Major findings of operation: Carcinoma left lung,

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Francis L. Greenfield M.D.

Address 2301 Annapolis Rd. 430 Date signed Aug 11 48

G655774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G655774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Fremont ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Serio, Concetta

3 (b) If veteran, name war →

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: Vincent Serio
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 11, 1887

8. AGE: Years	Months	Days	If less than one day
61	2	29	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

INFORMANT'S PARTICULARS

12. Name Samuel Pagora
13. Birthplace Italy
14. Residence 1 Battaglia Rotalia
15. Birthplace Italy
16 (a) Informant Man Pal Pagora
(b) Address 520 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral Director Frederick J. Ade
(b) Address 1211 W. Lombard St.

19 (a) (Date received by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-1948 at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1948 to 8-9 1948, and that I last saw her alive on 8-9 1948

Immediate cause of death Meningitis (organism undetermined) — Duration: 4 weeks

Due to Kidney carbuncle, left — Duration: approx same

Due to Cerebral thrombosis, left. — Duration: 3 weeks

Other Conditions Hypertension & V.D. Arteriosclerosis — Duration: unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Findings of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin D. Davis
Address West Baltimore General Hosp. Date signed 8-9-48 M. D.

G65775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G65775 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6903 Henderson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12

(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6903 Henderson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE H. GERMETEN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband (wife): Phillip H. Germeten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1889

8. AGE: Years 58 | Months 0 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rudolph Schmitt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Henry J. Germeten
(b) Address 3913 Ednor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery Lorraine Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9, 1948, at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Aug 9 1948.
and that I last saw him alive on Aug 8 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day

Due to Cerebral Arteriosclerosis — 4 yrs

Due to Hypertension — 4 yrs

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two) (Either)
(e) Means of injury

23. Signature A. J. Charlton M. D.
Address 1610 Eutaw Pl. Date signed Aug 10 48

G65776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G65776
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 645 Harvey St.
(c) Hospital or institution:

24 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MOLLIE V. MUNDIE

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-14-6121

4. Sex	5. Color or race	5 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband ~~or wife~~ Joshua R. Mundie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	3	10		

9. Birthplace Baltimore Md. (City, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Higgins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Eliza Dorsey
15. Birthplace Balto. Md.

16 (a) Informant Mr. J. R. Mundie
(b) Address 645 Harvey St. 39

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Immanuel Cem.
Location Manchester, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Fa. Aves. Balto. 17, Md

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948 at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 10 1948 and that I last saw her alive on Aug 10 1948

Immediate cause of death: Respiratory failure

Due to: Carcinoma of breast

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.
M. D.
Address 601 N. Monroe St Date signed Aug 11, 48

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G65777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65777

46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Edgemont Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Sergeant Hynson

3 (b) If veteran, name war: I World War
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy V. Hynson
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) March 16 1898

8. AGE: Years 50 | Months 4 | Days 25 | If less than one day: hr. / min.

9. Birthplace: Hampstead, Carroll Co. Md (Town, county, and state)

10. Usual Occupation: Supt. Public Schools
11. Industry or business: Education

12. Name: Mavis Hynson
13. Birthplace: Manchester Pa.

14. Maiden Name: Clara Perry
15. Birthplace

16 (a) Informant: Dorothy V. Hynson
(b) Address: 112 Edgemont Rd, Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 13 1948 (month) (day) (year)
(c) Cemetery or crematory: Hampstead Cem
Location: Hampstead Md

18 (a) Funeral Director: John G. Moran
(b) Address: 3004 Wells St

19 [illegible] (Local Registrar) (Date Received) Registered

MEDICAL CERTIFICATION

20 DATE OF DEATH Aug 10 1948, at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1947, to Aug 10 1948, and that I last saw h[illegible] alive on Aug 10 1948

Immediate cause of death: Hemorrhage Obstruction & small Metastases — Duration: 1 week

Due to: Carcinoma of sigmoid colon & — Duration: 8 mos.

Due to: peritoneal metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: Nov 29 1947

Major findings of operation: Carcinoma of sigmoid colon & metastases

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William P. Tilmore M. D.
Address: [illegible] Date signed: 8/13/48

G65778 BALTIMORE CITY HEALTH DEPARTMENT G65778
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Audrey Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-1905

8. AGE: Years	Months	Days	If less than one day
43	3	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Md. Drydock.

12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant Family
(b) Address 1834 Light Street.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month, day, year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director James L. McCauley
(b) Address 130 S. Fort Ave.

19 (a) 8-11 1948 (b) Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 3:26 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If ~~external cause was primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rayle M.D.
Medical Examiner.
Date signed

VS 151

G65779

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65779

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Aft Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Aft Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive B. Lawson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Married

6 (b) Name of husband or wife Allen R. Lawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1897

8. AGE: Years	Months	Days	If less than one day
51	2	3	hr. , min.

9. Birthplace Richmond W. Virginia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

EMPLOYER
12. Name Clowing Alley
13. Birthplace West Virginia

INFORMANT
14. Maiden Name of Mother Amanda Londermilk
15. Birthplace West Virginia

16 (a) Informant Allen R. Lawson
(b) Address 914 Aft Court

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Redwood
Location Redwood W. Va.

18 (a) Funeral director Lechlitner Funeral Home
(b) Address 39-41 Reisterstown Rd

19 (a) 1948 (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1948, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 , and that I last saw h[illegible] t alive on Aug 9, 19 48.

Immediate cause of death Pulmonary Oedema — Duration —

Due to cardiac failure — Duration —

Due to high blood pressure, Coronary heart disease — Duration 13 months

Other Conditions Contributing Cerebral hemorrhage, hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irma Newsome M. D.
Address 936 Patapsco Ave Date signed 8-10-48

VS 1

102

VS 2:

102

G65780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

G65780

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 West 37th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 -
(e) Length of stay in Baltimore (yrs., mos., or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland Country
(b) City or town Baltimore (If outside city or town limits, write R.R. and give town)
(c) Street No. 1431 West 37th Street (If rural, give location)
(g) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence F. Sigler

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-05-0515

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie F. Sigler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 30-1891

8. AGE: Years 57 | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace: Stanley, Virginia (Town, county, and state)

10. Usual Occupation: Laborer Supply Man

11. Industry or business: Marine Corps.

FATHER
12. Name: Unknown
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Fannie —
15. Birthplace: Virginia

16 (a) Informant: Mrs. Fannie F. Sigler
(b) Address: 1431 W. 37th Street

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: Aug. 12-1948 (mo., day, yr.)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore Co. Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 2231 Fells Road

19 (a) 1948 (Date received by registrar)
(b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/48 19 at 2.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/10/48

VS 15:

G65781

G65781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G65781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 Westheights Ave
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Westheights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

3 (a) FULL NAME Howard C. Buffington

3 (b) If veteran, name war. —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Hamilton R. Buffington

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 20 1862

8. AGE: Years 86 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Budds Mill, Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Foreman Cotton Mill

11. Industry or business Retired 25 years

FATHER 12. Name William Buffington

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Crabbs

MOTHER 15. Birthplace Maryland

16 (a) Informant Estate, Woodlawn

(b) Address 405 Montgomery St. Laurel, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12-1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3421 Girls Road

19 (a) Aug. 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, at 11:05 A.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature O. F. Thelander M.D. Medical Examiner.

Date signed 8/10/48

VS 151

G65782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75C

Registered No. G65782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division Street.
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ubrneth Hopkins.

3 (b) if veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Savannah Hopkins · 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18th 1902

8. AGE: Years	Months	Days	If less than one day
43	6	16	hr. min.

9. Birthplace Franklin Virginia
(Town, county, and state)

10. Usual Occupation Laboner.

11. Industry or business

FATHER
12. Name Sow Hopkins
13. Birthplace South Hampton, Va.

MOTHER
14. Maiden Name Annie Jones
15. Birthplace South Hampton Va.

16 (a) Informant Hospital Records.
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location W. Halstead

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 11 1948 (b) Registrar
(Date rec'd by registrar)

Registered in Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-48 19 , at 11:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-48 19 , to 8-3-48 19 , and that I last saw him alive on 8-2 19 48

Immediate cause of death	Duration
Hypostatic Pneumonia	
Hepatic & splenic congestion.	
Due to Convulsions after determined cirrhosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See AMA Cause of death

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simon H. Carter jr. M. D.
Address Provident Hosp Date signed 8-6-48

WE 150

G65783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G65783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Vine St.
(c) Hospital or institution 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Hollis

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Samuel.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/1863

8. AGE: Years 84 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Sheen

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Williams

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Rachael Wenyan (D)

(b) Address 813 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk

Location Baltimore County, Md.

18 (a) Funeral director Charles L. Cooper

(b) Address 512 N. Carrollton Ave

(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8/48 19 , at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 8 1948 and that I last saw h alive on 8/7 1948.

Immediate cause of death

(a) Stroke Regurgitation — Duration 2 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Hulet M.D.

Address 1 W S Preston Date signed 8/9/48

G65784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

G65784
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 19 Newborn
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 W Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Lucille Lyons.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-11-48.

8. AGE: Years | Months | Days | If less than one day hr. 2-3 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Lyons.

FATHER
12. Name Maryland W Lyons
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn M Harris.
15 Birthplace North Carolina.

16 (a) Informant Father - above.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8, 11, 48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1424 Light St.

10 (1) 1948 (Date) (Signature of registrar) Thomas F. Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1948 to 8-11 1948 and that I last saw her alive on 8-11 1948.

Immediate cause of death Fetal anoxia in utero.

Due to prolapsed cord.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address Date signed

G65785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65785
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Elm Ave
(c) Hospital or institution:
12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1863

8. AGE: Years 85 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert E Barnes
13. Birthplace Md

MOTHER
14. Maiden Name Annie Gamber
15. Birthplace Md

16 (a) Informant Mary C Barnes
(b) Address 3504 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 48 (month) (day) (year)
(c) Cemetery or Crematory Greenmount M. P.
Location Gamber Md

18 (a) Funeral director Frank H Seitz
(b) Address 914 N Eutaw St

19 (a) Date received by registrar 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to Aug 9th 1948 and that I last saw h[illegible] alive on Aug 9th 48

Immediate cause of death (a) Cerebral Hemorrhage
Etc

Due to Arteriosclerosis, Senility, Prostate Trouble

Due to Infection

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B A Leitch M.D.

Address 3615 Fare. 150 Date signed Aug 10/48

VS 150

G65786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65786 X 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore - Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Crafton ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kate E Wehr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Ferdinand Wehr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Nov 30 1891
8. AGE: Years 56 | Months 8 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frederick Brecklander
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret
15. Birthplace

16 (a) Informant FERDINAND WEHR
(b) Address 1931 CRAFTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug 12 1948 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location 7225 EASTERN AVE

18 (a) Funeral director Roland L Fuchs
(b) Address 2112 LUNDALE AVE DUNDALK 22 MD

19 (a) (Registrar) (b) Registrar

NO 1 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1948 at 8:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/31 1948 to 8/9 1948 and that I last saw him alive on 8/9 1948.

Immediate cause of death: Cardiac failure — Duration
Cerebral vascular accident
Just prior
Due to Myocardial degeneration
Due to Diabetes Mellitus

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Anticipated, CPC 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Mentz M.D.
Address Church Home Date signed 8/10/48

A.B-31482 G65787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G65787
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Donoghue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. ?-1860

8. AGE: Years 87 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John W. Reddall or John W. Riddall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eleanor Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave & Rose St

18 (a) Funeral director Clayton Hoffman
(b) Address 1639 Broadway

19 (a) [illegible] rec'd by reg. (b) [illegible] Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10- 1948, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9- 1938, to 8-10- 1948 and that I last saw her alive on 8-10- 1948

Immediate cause of death Cerebrovascular Accident — Duration 19 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan Barbold, M. D.

Address Balt. City Hosp. Date signed 8/11/48

065788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 5788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? No! Yes or No? If yes, name country

3 (a) FULL NAME William O. Thomas Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian J. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1912

8. AGE: Years 36 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation Accountant Ratio Examiner

11. Industry or business U.S.G.

FATHER: 12. Name Franklin Thomas
13. Birthplace Mich.

MOTHER: 14. Maiden Name Grace Brewster
15. Birthplace Mich.

16 (a) Informant Lillian Thomas
(b) Address 7?? West Hills Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13/48 (Month) (Day)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date registered

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1948, at 9 15 AM

21. I certify that I took charge of the remains described above, held an Autopsy / Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-10-48 at Approx. 6 15 AM.
(b) Where did injury occur? 220 N. Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Illuminating gas poisoning

23. Signature Emil Ryan M.D.
Medical Examiner.
Date signed 8-10-48

65789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G65789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Spring St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Nichols
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1880

8. AGE: Years 68 Months 4 Days 29 If less than one day hr. min.

9. Birthplace (Town, county, and state) Lancaster Co. Va.

10. Usual Occupation Laborer

11. Industry or business Canton R.R

FATHER
12. Name Robert Nichols
13. Birthplace ?

MOTHER
14. Maiden Name Margaret (Penn)
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Howland Funeral Home
(b) Address 1631 Edmondson Ave

19 (a) AUG 1 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 6.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3- 1948 to 8-8 1948 and that I last saw him alive on 8-8 1948

Immediate cause of death Colonic Abscess Encapsulated Peritonitis — Duration

Due to Ruptured Diverticula of Colon

Due to Splenic and Hepatic Congestion

Other Conditions Pulmonary Congestion and edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon P. Carter, Jr. M. D.
Address Date signed

VS 750

Please write the cause of death clearly and legibly.

BC-48-1773 ✓ 66730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registration No. 66730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Harford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Calvo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (d) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 7, 1948

8. AGE: Years — | Months — | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Frank Calvo

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Margaret Grassmuck

15. Birthplace Baltimore Md

16 (a) Informant Frank Calvo - Father

(b) Address 2922 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd - Balt. Md

18 (a) Funeral director Fusselle Della Vore

(b) Address 322 S. Highs St.

19 AUG 11 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948, to Aug 11 1948, and that I last saw him alive on Aug 11 1948.

Immediate cause of death Respiratory Failure
Mechanical

Due to Aspiration - Aspiration
Pneumonia

Due to Congenital

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Fred R. McDaniel Jr. M.D.

Address University Hosp. Date signed 8/11/48

VS 180

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registration No. C65791

C65791

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City Hospital
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Boa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Chase,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT MAJOR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years 6 | Months | Days | If less than one day: hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business

FATHER
12. Name ROBERT MAJOR SR.
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name THAIS JOHNS
15. Birthplace CHASE, MD

16 (a) Informant ROBERT MAJOR SR
(b) Address CHASE, MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 12, 1948 (month) (day) (year)
(c) Cemetery or crematory SHARP ST CEMETERY
Location CHASE, MD

18 (a) Funeral director HOLLAND FUNERAL HOME
(b) Address 163 UNION HILL AVE

19 (a) AUG 11 1948 (Date received by registrar) Baltimore, Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 7:14P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain,
Fracture of right femur

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐, or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-8-48 at Approx. 6:50 P. M.
(b) Where did injury occur? Chase, Maryland (Eastern Avenue)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by Auto.

23. Signature [signature] M.D.
Medical Examiner
Date signed 9 Aug 48

065792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. 065792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-5079

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife M. Pauline Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25th 1886

8. AGE: Years	Months	Days	If less than one day
62	5	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Edward T. Carroll
13. Birthplace ?

MOTHER
14. Maiden Name Mary B. Gittings
15. Birthplace ?

16 (a) Informant M. Pauline Carroll
(b) Address 523 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Monument Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 12 1948 (Date rec'd by registrar) Kunkel Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th 1948 at 7 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19- 1948 to 8-10- 1948, and that I last saw h alive on 8-10- 1948.

Immediate cause of death
Cancer - Stomach
with Metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration 6 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Nunn, M.D.
Address 448 N. Longwood Date signed 8-11-48

V S 150

665793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 665793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della A. Blankenship

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wyatt Blankenship
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1884

8. AGE: Years	Months	Days	If less than one day
64	2	23	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Hezekiah Forrest
13. Birthplace Va.

MOTHER
14. Maiden Name Martha P. Hutson
15. Birthplace Va.

16 (a) Informant Wyatt Blankenship
(b) Address 929 N. Charles St

17 (a) Burial (b) Date thereof 8/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St

19 (a) AUG 12 1948 (b) Registrar
(Date rec'd by registrar)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948, at 2.15 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1942 to Aug. 8 1948 and that I last saw h alive on Aug 8 1948.

Immediate cause of death	Duration
Cerebral hemorrhage 2	
Embolism 1	
Due to Cardiac Failure	
Due to Hypertensive Cardio-vascular disease.	
Other Conditions.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. Lederman M. D.
Address 32 Forest Place Date signed Aug. 9 1948

Balto 12

8.3a

065794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 065791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Nicoll Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Nicoll Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Warehime

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary R. Warehime
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1867

8. AGE: Years	Months	Days	If less than one day
81	1	0	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

PARENTS

12. Name Reason F. Warehime
13. Birthplace Pa.

14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant Reason F. Warehime
(b) Address Mt. Airy, Md. R.F.D. #3

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Calvary Methodist
Location Taneytown, Carroll Co. Md.

18 (a) Funeral director William Crook Inc.
(b) Address 121 E. Pratt St.

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 1635 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1948 to August 10 1948 and that I last saw h[illegible] alive on August 7 1948

Immediate cause of death	Duration
Multiple cerebral thrombosis	11 days
Due to Cardiac decompensation	2 years
Due to Arteriosclerosis, generalized severe	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Frederick A. Vollmer M. D.
Address 600 York Road Date signed 8-10-48

VS 220

665795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-16727 159

Registered No. 665795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl HARDY ("A") (C)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 5 1948
8. AGE: Years | Months | Days 5 | If less than one day hr. min.
9. Birthplace Univ. Hosp. Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Hardy
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ursa Mary Hardy Mosier
15. Birthplace Balto Md

16 (a) Informant Bernard Hardy
(b) Address 905 Burgundy st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 S. Paca st

19 (a) AUG 12 1948 (Date rec'd by Local Reg.) (b) Washington Boulevard, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1948, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/48 19 to 8/10/48 19 and that I last saw h alive on 8/10 19 48

Immediate cause of death Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred C. Willmott Jr. M. D.
Address University Hosp. Date signed 8/11/48

VS 150

655796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 655796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 W. 25th St.
(c) Hospital or institution: Sinai Hospital of Baltimore, 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Skarbalis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-3055

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cecil Anne Skarbalis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1903

8. AGE: Years 45 46 | Months 3 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Bar & Restaurant

12. Name Manuel Skarbalis

13. Birthplace Greece

14. Maiden Name (Markaroni)

15. Birthplace "

16 (a) Informant Mrs. Cecil Skarbalis

(b) Address 120 W. 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

AUG 12 1948 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 655 M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 19 48 to Aug. 10 19 48 and that I last saw h[im] alive on Aug. 10 19 48

Immediate cause of death

Due to Miliary TBC

Due to

Other Conditions Leukemia?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: TBC -

of autopsy: Microscopic not done yet

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Silverstein

Address Sinai Hospital Baltimore Date signed 8/11/48

Chas. Silverstein X

VS 180

G65797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G65797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Rural (Joppa) (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Mae Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ralph W. Bowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) oct. 16 1916

8. AGE: Years 31 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name John Hamilton
13. Birthplace Kentucky

MOTHER
14. Maiden Name Minnie Baldwin
15. Birthplace Georgia

16 (a) Informant Ralph C. Bowman
(b) Address R.F.D. # Joppa Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Wellsburg
Location Brook Co. W. Va.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1948, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1948 to 8-12 1948, and that I last saw her alive on Aug 11 1948.

Immediate cause of death Cardio-resp. walking failure

Due to Generalized Dyspnea Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. G. Martin M.D.
Address Maryland Gen. Hosp. Date signed 8-12-48 M. D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G65758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Reber - Florence Viola Reber

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harold W. Reber

6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.) 1-24-01

8. AGE: Years 47 | Months 7 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Pa - Reading
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph [redacted] Baum
13. Birthplace: Pa. - Reading

MOTHER
14. Maiden Name: Sallie Baum
15. Birthplace: Pa. Reading

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory: Pleasant View
Location: Sparrows Point, Md.

18 (a) Funeral director: [redacted]
(b) Address: Sparrows Point, Md.

19 AUG 12 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11, 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948 to Aug 11 1948 and that I last saw her alive on Aug 11 1948

Immediate cause of death: (a) Coronary thrombosis
Malignant hypertension
Uremia

Due to: Malignant Hypertension

Due to: Arteriosclerosis

Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: Arteriosclerosis changes kidneys, heart

Duration
[illegible]
5 Days
1 year
6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: John [redacted] Harvey M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

G65799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G65799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 S. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Hanley Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Michael Doyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1852

8. AGE: Years 96 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Texas Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Owen Hanley
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine —
15. Birthplace Ireland

16 (a) Informant Owen J. Doyle
(b) Address 308 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 13-1948 (month) (day) (year)
(c) Cemetery or crematory St Joseph's Cem
Location Govans Md

18 (a) Funeral Director Pott & Co B. M. Walker
(b) Address Pott & Strickers St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948 at 4 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1943 to Aug 11 1948 and that I last saw her alive on Aug 10 1948

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to

Due to

Other Conditions generalized arteriosclerosis — uncertain

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Roenon M. D.
Address 206 S. Gilmor St. Date signed 8-11-48

VS 190

G65800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75a

Registered No. G65800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Evelyn (EVELYN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 9-26-83

8. AGE: Years 64 Months 65 + 10 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Terrence

13. Birthplace Va.

MOTHER 14. Maiden Name Alice Berman

15. Birthplace Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto

18 (a) Funeral director Rayner Sanders

(b) Address 1442 E. Preston St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

20. DATE OF DEATH 8-10-48 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-48 to 8-10-48, and that I last saw ~~her~~ alive on 8-10 1948.

Immediate cause of death: Terminal bronchopneumonia — Duration: Days

Due to Severe Cachexia — Minutes

Due to Aplastic anemia with hepatomegaly and splenomegaly — Hours

Other Conditions — Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Anemia, hepatomegaly, splenomegaly.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Courtney J. Page M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-12-48

VS 150

65801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 65801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Hargrove St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
55				

9. Birthplace Montpelier S.C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace SC

MOTHER
14. Maiden Name Unknown
15. Birthplace SC

16 (a) Informant Mrs. Florena Berry
(b) Address 2101 Hargrove St

17 (a) Burial (b) Date thereof 8-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bells National
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) AUG 12 1948 (b) Pikesville Baltimore, Md.
(Date rec'd by registrar) (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 9:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy & dilatation of the heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl Rose M.D.
Medical Examiner.

Date signed 8-10-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 665802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard PORTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Solomon Porter

13. Birthplace Va

MOTHER 14. Maiden Name Lou ?

15. Birthplace Va

16 (a) Informant Mr. Tom Porter

(b) Address 1211 N Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Balto

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1147 E Preston St

19 (a) Filed AUG 12 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1948, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy/Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to Malnutrition.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George F. Merrill M.D.
Medical Examiner.

Date signed 8/9/48

VS 151

665803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

Registered No. 665803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1205 McElderry St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME (Ervin) Ervey Clary

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
40			hr. ..... min.

9. Birthplace Brunswick Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER
12. Name John Clary
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Tucker
15. Birthplace Va

16 (a) Informant Louis Clary
(b) Address Brunswick Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory Lawrenceville
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) AUG 10 1948 (Date received by Registrar) Beatrice for Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948, at 7½ P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull & intracranial hemorrhage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-30-48 at 9:45 P.M.
(b) Where did injury occur? Front of 1105 McElderry St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by fist

23. Signature ..... M.D. Medical Examiner
Date signed 8-7-48

VIE 231

G665804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G665804 Registered No. 122B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Woodwald Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME ELLA MAGILL [Henry]

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas MAGILL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edwd. Monahan
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Moulone
15. Birthplace Ireland.

16 (a) Informant Mrs. Thomas Magill
(b) Address 3704 Woodwald Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (c) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) Aug 12 1948 (Date received by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Aug 11 1948, and that I last saw her alive on Aug 11 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Pneumonia

Due to Intestinal Obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature John Rehberger M. D.
Address St Joseph's Hosp Date signed 8-11-48

VS 150

65805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G65805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Street
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 276 W. 5th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry C. James

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Widower

6 (b) Name of husband or wife ~~Ella Braley Sapp~~

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 2 1866

8. AGE: Years	Months	Days	If less than one day
81	9	7	hr. min.

9. Birthplace Frederick, Frederick, Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

MOTHER
12. Name Emma C. James
13. Birthplace Va.

FATHER
14. Maiden Name Emma Albaugh
15. Birthplace Md.

16 (a) Informant Mr. Harry T. James
(b) Address Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

19 Aug 12 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948 at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1948 to August 11 1948 and that I last saw h alive on Aug. 11, 1948

Immediate cause of death

Respiratory & cardiac failure — Duration

Due to Coronary thrombosis — 25 min.

Due to Arteriosclerotic C. V. disease — Years

Other Conditions B.P.H. (Benign prostatic hypertrophy)
(Include pregnancy within 3 months of death)

Date of operation 8/4/48

Major findings of operation: Enlarged fibrous prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature J. J. Meaudant Jr. M. D.
Address University Hospital Baltimore, Md. Date signed 8/11/48

VS 150

665806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 665806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dft
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence (~~Van Story~~) Van Story

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Charles Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown —

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown —

13. Birthplace

14. Maiden Name Florence Cornish

15. Birthplace Balto, Md.

16 (a) Informant Charles Vansteps

(b) Address 915 Leadenhall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 M 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. Md.

18 (a) Funeral director Walter B. Fry

(b) Address 1310 Hanover St.

19 (a) AUG 12 1948 (b)
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/48 19 . at 12:30 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Chronic Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 8/10/48

65807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

65807 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.H.
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Woodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace LUMBERG Co. VA. (Town, county, and state)

10. Usual Occupation LABORER.

11. Industry or business

FATHER 12. Name WM. WOODSON,
13. Birthplace VA.

MOTHER 14. Maiden Name LUCY GEE
15. Birthplace VA.

16 (a) Informant LUCY HAWTHORNE
(b) Address 928 Payson St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 14 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn 8 14 48
Location

18 (a) Funeral director A. HALSTEAD
(b) Address 614 Druid Hill Ave.

19 (a) AUG 12 1948 (Date rec'd by registrar)
(b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 9:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following.
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schwaber M.D. (Medical Examiner.)
Date signed 8/11/48

VS 151

5803

ES121374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town ... (If outside city or town limits, write RURAL and give town)
(d) Street No. ... (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME John Winston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr) Oct. 3, 1879

8. AGE: Years	Months	Days	If less than one day
68?	10	4	... hr. ... min.

9. Birthplace ? Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Patrick Winston
13. Birthplace ? Md.

MOTHER
14. Maiden Name ? Eliza Nash
15. Birthplace ? Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location ...

18 (a) Funeral director Robert Lee S. Williams
(b) Address 322 E. Lanvale St.

19 (a) AUG 12 1948 (b) Herbert Boynton Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ... 19 ... at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h[illegible] alive on ... 19 ...

Immediate cause of death Subarachnoid Hemorrhage — Duration 1 week
Due to ...
Due to ...
Other Conditions Bronchopneumonia — 1 week
(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operation: ...
of autopsy: Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature John Beckstold
Address Balto. City Hosp. Date signed 8/10/48

VS 150

G65809

RICKS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G65809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Rutland Ave.
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Rutland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Ricks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1876

8. AGE: Years	Months	Days	If less than one day
72	6	4	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Laborer (Retired)
11. Industry or business steel

FATHER 12. Name Elijah Ricks
13. Birthplace N.C.

MOTHER 14. Maiden Name Martha Mitchell
15 Birthplace N.C.

16 (a) Informant Maggie Wilson
(b) Address 916 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1948 (month) (day) (year)
(c) Cemetery or crematory Gibutus Memorial Pk.
Location Gibutus Md.

18 (a) Funeral director Mrs. Robt. G. Elliott & Daughter
(b) Address 1125 N. Carolina Ave.

AUG 12 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948, at 6 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1948 to 8-9 1948 and that I last saw him alive on 8-8 1948

Immediate cause of death: Carcinoma of pancreas — Duration: 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE 5, MD.
Date signed 8-11-48

vs

G65810

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G65810

C65810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. C65810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Wyman Park Drive. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Libbie V. McNamara

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife John A. McNamara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 6, 1885

8. AGE: Years 62 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John A. McNamara.
(b) Address 321 Wyman Park Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location

18 (a) Funeral director Paul E. Schenning Jr.
(b) Address 1115 N Charles St.

19 AUG 12 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1948; at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1948 to 8-11 1948, and that I last saw h[illegible] alive on 8-11 1948.

Immediate cause of death Post Operative Cardiac failure.

Duration

Due to operation for Cholecystectomy and Exploration of common duct

Due to

Other Conditions Cardiac pathology prior to operation.
(Include pregnancy within 3 months of death)

Date of operation 10 Aug. 48.

Major findings of operation: Cholecystitis & Cholelithiasis - Stone common duct.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J R Liberto
Address Bon Secours Hosp Date signed 8/11/48 M D

VS 120

G65811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G65811

Please write clearly and legibly. Use ink. Do not use pencil. If certificate is made in error or death certify and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 W. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 17, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	24	hr. min.

9. Birthplace Connecticut
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace M

MOTHER
14. Maiden Name Unknown
15. Birthplace M

16 (a) Informant Mrs. Annie Richardson
(b) Address 214 W. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Aug 12 1948 (Date rec'd by Registrar) (b) [signature] Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948 at 5:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/9/48 19 to 8/10 1948, and that I last saw him alive on 8/9/48 19

Immediate cause of death: Hypertensive Cardio-Vascular Disease — Duration: 48 hrs.
Due to
Due to
Other Conditions
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Marion Grant, M.D.
Address 601 N. [illegible] Date signed 8/10/48

VS 153

G65812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G65812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1039 Hollins St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank V. Falice

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jessie C.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr) Jan 1st 1891

8. AGE: Years 57 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business Self

FATHER
12. Name Samuel Falice
13. Birthplace Italy

MOTHER
14. Maiden Name Nina
15. Birthplace Italy

16 (a) Informant Mrs Jessie C. Falice
(b) Address 1039 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cem
Location 4300 Old Frederick Rd

18. (a) Funeral director John J. Lowan & Son
(b) Address 901-03 Hollins St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10th 1948, at 5-05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to 10 Aug. 1948, and that I last saw him alive on Aug. 10 1948

Immediate cause of death (a) Cerebral Hemorrhage
Due to (b) Carcinomatosis
Due to (c)
Other Conditions Diabetes Mellitus
Tuberculosis of Spine
(Include pregnancy within 3 months of death)

Duration: (a) 1 day; (b) unk.; (c) years.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Lomardo M.D.
Address 910 W. Lombard Date signed 11 Aug. 1948.

VS 159

G65813 Witter ✓ G65813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Belle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, adjoining town)
(d) Street No. 3707 Belle ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosalie Witter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John H. Witter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/12/1859

8. AGE: Years 88 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Henry Stutzman

13. Birthplace Germany

MOTHER 14. Maiden Name Renega Beck

15 Birthplace Germany

16 (a) Informant Mr Frank E. Witter

(b) Address 3707 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 600 Frederick Road

18 (a) Funeral director J. Olney Boyce

(b) Address 1318 Lexington St.

19 (a) Date Rec'd by registrar AUG 12 1948 (b) Registrar

Registration No. 1948-

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug 11 1948 and that I last saw h alive on Aug 10 1948

Immediate cause of death — Chronic Endocarditis — Duration 1 yr

Due to Arteriosclerosis — 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify any other place)
(e) Means of injury

23. Signature C. J. Whelan M.D.

Address 1279 Hilburn Ave Date signed 8/14/48

VS 150

G65814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Howard St
(b) Street address [redacted] 15
(c) Hospital or institution: Maryland [redacted] General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife LENA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1881

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation RETIRED POLICEMAN

11. Industry or business

FATHER 12. Name MAX MILLER
13. Birthplace RUSSIA

MOTHER 14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory AITZ CHAIM
Location WASH. BLVD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW Pl. Baltimore, Md

19 (a) [redacted] by registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/48 19 , at 445 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 8/11 1948, and that I last saw h alive on 8/10/48 19 .

Immediate cause of death
Coronary Occl. Sclerosis
Myocardial Infarction

Duration ?
4 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson B Kush, M.D.
Address 2320 Eutaw Place Date signed 8/11/48

G65815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Levin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — 1884
8. AGE: Years 64 | Months | Days | If less than one day: hr. min.
9. Birthplace ~~Latvia~~ Russia
(town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Lena Levin
(b) Address 212 No Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Brai Israel
Location Loudenslager Ave

18 (a) Funeral director Jack Lewyn Inc
(b) Address 2106 Eutaw Place

(a) (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1948 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12, 1948 to Aug 12 1948, and that I last saw h[illegible] alive on Aug 12 1948

Immediate cause of death: Coronary Thrombosis — Duration: ½ hour
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2209 Eutaw Place Date signed 8/17/48

VS 159

G65816

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G65816

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Mexico (b) County
(c) City or town Taos (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 343 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Lawrence Smithwick

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Lyna Smithwick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 28, 1912

8. AGE: Years	Months	Days	If less than one day
35	8	14	hr. min.

9. Birthplace New York City, (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name Francis Smithwick
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McCabe
15 Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Fair View Cem
Location Santa Fe-New Mexico

18 (a) Funeral director Wm Cook Jrs
(b) Address 1217 St Paul St

AUG 12 1948 (Date received by registrar) (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1948 to Aug. 12 1948, and that I last saw him alive on Aug. 12 1948.

Immediate cause of death 1-Carcinomotosis, primary site undetermined — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Twn) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. F. VAN HEKERN X
Address U S Marine Hospital Date signed 8-12-48

J. F. VAN HEKERN X

G65817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 E

Registered No. G65817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 W. Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora A. Crummett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 15 1866

8. AGE: Years 81 | Months 10 | Days 3527 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stephen Reynolds
13. Birthplace Virginia

MOTHER 14. Maiden Name Elizabeth Lam
15. Birthplace Virginia

16 (a) Informant Lelia B. Coleman
(b) Address 3806 W. Hamilton Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Rhodesville
Location Rhodesville, Va.

18 (a) Funeral director Loring Byrd
(b) Address 500 E. Baltimore

19 (a) 8-12 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1948, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Aug 12 1948 and that I last saw h alive on Aug 11 1948

Immediate cause of death Shock — Duration 8 hrs.

Due to Hemorrhage following excision of large Carbuncle

Due to

Other Conditions Tumor in abdomen

(Include pregnancy within 3 months of death)

Date of operation 8-11-48

Major findings of operation: Ca. Lymph c Gangrene on back

of autopsy: denied permission

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Grattan M.D.
M. D.
Address Maryland Gen. Hosp. Date signed 8-12-48

G65818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G665818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4806 Monuments Ave
(c) Hospital or institution:
Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 + 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Springfield Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Margaret L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1875

8. AGE: Years 72 | Months 9 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Dearing
15. Birthplace Ireland

16 (a) Informant Margaret L. Murphy
(b) Address 714 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cemetery
Location Old Frederick Road
Baltimore County, Md

18 (a) Funeral director Baltimore County Undertaking Co
(b) Address 3000 E Baltimore St

AUG 12 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Aug 1948 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to
Hypostatic C.V.
Diabetes

Other Conditions
(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature Emil L. Rogy M.D. Medical Examiner
Date signed 11 Aug 48

107

G65819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G65819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Milan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-84

8. AGE: Years 64 | Months 6 | Days 3 | If less than one day hr. min. 20

9. Birthplace No. Carolina (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name Paul Lloyd
13. Birthplace No. Carolina
14. Maiden Name Melissa Strickland
15. Birthplace No Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Blandenfield Ave

19 (a) AUG 12 1948 (b) Registrar

MEDICAL CERTIFICATION 55-A

20. DATE OF DEATH August 10 1948 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1948 to 8/10 1948. and that I last saw h alive on 8/10 1948.

Immediate cause of death: Uremia — Duration: Aug 1947

Due to: Carcinoma of Ant. Abd. wall & C. widespread — 1948

Due to:

Other Conditions: metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Watt, Jr. M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

G65820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G65820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Rider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Rider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 23, 1887

8. AGE: Years	Months	Days	If less than one day
61	4	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Edward Rider
13. Birthplace Maryland

MOTHER
14. Maiden Name Andie Ball
15. Birthplace Maryland

16 (a) Informant Anna Rider
(b) Address Joppa Rd - Brooklyn Park

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Timonium, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1948 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1948 to 8/9 1948 and that I last saw h[illegible] alive on 8/9 1948

Immediate cause of death: Cardiac failure

Due to Lung abscess

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not obtained

Duration
3-4 months
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 8/9/48

VS 150

665821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 665821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6004 Bertram
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Bertram (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence E. Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Elizabeth C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 (1880)

8. AGE: Years	Months	Days	If less than one day
67 (68)	4	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Crown, Cork & Seal

FATHER
12. Name George H. Green
13. Birthplace

MOTHER
14. Maiden Name Theresa Duffey
15. Birthplace

16 (a) Informant Mrs. Elizabeth Green
(b) Address 6004 Bertram Ave

17 (a) Burial (b) Date thereof 8/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Balto

18 (a) Funeral director L. J. Leuck
(b) Address 5305 Harford Rd

19 (a) AUG 12 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Aug. 1948, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner.
Date signed 12 Aug. 1948

VH 121

G65822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G65822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 43, Route 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gagen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 8/10/48

8. AGE: Years	Months	Days	If less than one day
			11 hr. 7 min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Russell D. Gagen
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Md

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Lidy Luck
(b) Address 5305 Belair Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, at 7:37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/1948 to 8/10 1948, and that I last saw her alive on 8/10 1948.

Immediate cause of death	Duration
Respiratory Failure	10 min
Due to Atelectasis	11 hr
Due to Prematurity	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas A. Duggan M.D.
Address Mercy Hospital Date signed 8/12/48

VS 159

665823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66B

Registered No. 665823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-7
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Alameda Blvd #18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Farrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/04

8. AGE: Years 44 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Rhode Island (Town, county, and state)

10. Usual Occupation Worker

11. Industry or business

FATHER 12. Name Wm. James Farrell
13. Birthplace R. Island

MOTHER 14. Maiden Name Helen F. Fitzpatrick
15. Birthplace Md

16 (a) Informant Mr. Thomas Farrell
(b) Address 2904 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director J. J. Luck
(b) Address 5 Harford Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 9:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/7 1948 to 8/11 1948, and that I last saw h alive on 8/11 1948.

Immediate cause of death: Cardiac failure — Duration
Due to: Hyper tension
Due to:
Other Conditions: Obesity moderate
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Blazer
Address Maryland Gen. Hosp. Date signed 8/12/48

VS 150

102

65824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a ✓

Registered No. 65824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 McCulloh St.
(If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnston

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth C. Johnston
6 (c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): Feb. 6 1876
8. AGE: Years 72 | Months 6 | Days 25 | If less than one day ... hr. ... min.
9. Birthplace: Harrisville, Md. (Town, county, and state)
10. Usual Occupation: Teacher
11. Industry or business

FATHER
12. Name: William Johnson
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Susan Cook
15. Birthplace: Balto. Co. Md.

16 (a) Informant: Mrs. Elizabeth C. Johnston
(b) Address: 2456 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Balto. Md.

18 (a) Funeral director: Wm. J. Chatmon Jr.
(b) Address: 1701 McCulloh St.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Filed by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25-48 to 8-11 1948 and that I last saw him alive on 8-11 1948

Immediate cause of death: Acute Myelogenous Leukemia — Duration: 7

Due to:

Due to:

Other Conditions: Pernicious Anemia — Duration: 7.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: Acute Myelogenous Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Bernard Harris M. D.
Address: 120 N. Carey St. Date signed 8/19/48

VS 180

Bernard Harris

G65825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G65825
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 La Salle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 La Salle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin E. Gemmill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence D. Gemmill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 20-1893

8. AGE: Years	Months	Days	If less than one day
55	1	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Elec. Maintenance Foreman
11. Industry or business Govt. Harm. Piers Repairs

FATHER
12. Name Robert K. Gemmill
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Echo
15. Birthplace Md

16 (a) Informant Mrs. Florence D. Gemmill
(b) Address 4114 La Salle ave

17 (a) Burial (b) Date thereof 8-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore Co Md

18 (a) Funeral director Geo. E. Harper Jr
(b) Address 5½ Hollins St
(c) Baltimore, Md

AUG 12 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1948, at 6.45A

21. I certify that death occurred on the date above stated; that I attended deceased from 29. 12. 1947, to 20. 6. 1948, and that I last saw him alive on 20. 6. 1948.

Immediate cause of death	Duration
Heart failure	
Due to Chronic bronchitis and emphysema with asthma, severe	29 yrs.
Due to	
Other Conditions Chronic glomerulo-nephritis	2

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Rivers M. D.
Address 7122 Harford Rd Date signed 11 Aug 48

VS 150

106C

G65826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G65826
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Fairwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Edmondson ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lee Watts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Nellie May Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 - 1870

8. AGE: Years	Months	Days	If less than one day
77	7	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Elevator operator (Ret)
11. Industry or business

FATHER
12. Name Oliver Watts
13. Birthplace Md

MOTHER
14. Maiden Name Sophie Weller
15. Birthplace Md

16 (a) Informant Mrs Nellie May Watts
(b) Address 714 Edmondson ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Western cem.
Location Baltimore Md

18 (a) Funeral director Geo. L. Rogers Jr
(b) Address 1512 Hollins St Catonsville, Md

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1948 at 0 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-48 1948 to 8-11 1948 and that I last saw h/ alive on 8-11 1948

Immediate cause of death Respiratory failure

Due to Pulmonary Edema

Due to Arteriosclerotic C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Woverly Date signed 8/14/48

VS 150

Pd G65827

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G65827
Registered No.

CERTIFICATE OF DEATH 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington D.C. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5236 Nebraska ave (If rural give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country

3 (a) FULL NAME John Tavenner

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.) 10-31-89

8. AGE: Years 58 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Richard Tavenner
13. Birthplace Va

MOTHER
14. Maiden Name Molly Beals
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal)
(b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Washington D.C.

18 (a) Funeral director J. Wellington Lee's Son Co.
(b) Address 706-14th St Washington D.C.

16 12 1948 (Date rec'd by registrar)

(b) [illegible] Washington D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-1948, at 12:45 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23-1948 to 8-12-1948, and that I last saw him alive on 8-12-1948.

Immediate cause of death: Cholemia and Coma — Duration: 1 day
Due to: Cirrhosis of the Liver — Duration: 6 months
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify in public place)
(e) Means of injury
23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

X

G65828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G65828

CH. 120118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 W. Lombard ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. McHale

3 (b) If veteran, name war Methodist

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of ~~husband or~~ wife Henrietta McHale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 21 1883

8. AGE: Years 66 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Freight Conductor

11. Industry or business

FATHER
12. Name Thomas McHale
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McHale
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (~~Burial, cremation,~~ or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) ~~Cemetery or crematory~~ St. Josephs
Location Staten Island N.Y.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St
(c) Date received AUG 13 1948 Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 7 - 1948 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6- 1 -1948, to 8- 7- 1948 and that I last saw him alive on 8 - 7- 1948.

Immediate cause of death Myocardial Infarction — Duration 4 Days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Bechtold
Address Balt. City Hosp. Date signed 8/14/48

VS 150

65829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 12B

Registered No. 65829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot
(c) Hospital or institution: So. Balt. General Hospital

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside limits, give township)
(d) Street No. 1013 Peach Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Alberta Marston (Tubman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas Tubman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1895

8. AGE: Years 52 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Ht Wk

11. Industry or business

FATHER
12. Name Harrid Marston
13. Birthplace Md

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Md

16 (a) Informant Thomas Tubman
(b) Address 1013 Peach Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co. Md

18 (a) Funeral director Isaac H. Bowers
(b) Address 108 W Monument St

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1948, at 7 24 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fulmer M.D. Medical Examiner.
Date signed 8/9/48

VS 151

G65830 SC-B-4240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G65830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 412 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/48

8. AGE: Years	Months	Days	If less than one day
			7 hr. 10 min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Akron Ohio

MOTHER
14. Maiden Name Mildred Pearson
15. Birthplace Littleton, N.C.

16 (a) Informant Mildred Johnson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director [illegible] AUG 12 1948
(b) Address

19 (a) Aug 3 1948 (Date received by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1948, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6:20 PM 8-7 1948, to 8-8 1948, and that I last saw h[illegible] alive on 8-8 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Subcutaneous Emphysema	
Due to Premature 33 weeks	
Other Conditions Chronic Contin[illegible] Hands, Complete Chest	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Bold M. D.
Address Univ. Hosp. Date signed 8-8-48

VS 190

X 1

665831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 665831

AC = 12-1278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town 38 Kingston Pk. Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Kingston Park (If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Truce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/10/48

8. AGE: Years | Months | Days | If less than one day 18 hrs. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Garman Truce
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Knight
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 12 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd) Registrar Dwight H. Williams, M.D. Registrar

AUG 12 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948, at 11.11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948, to Aug. 10 1948, and that I last saw him alive on Aug. 10 1948.

Immediate cause of death: Intracranial hemorrhage — Duration: 18 hrs

Due to: Birth Injury

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: fracture, skull; Cerebral cortex

of autopsy: Atelectasis, Left Lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Dorman Jr. M. D.

Address 3101 St. Paul St. Date signed Aug. 10, 1948

065832 48-14561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 065832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town) MADISON AVE
(d) Street No. 1711 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-30-48

8. AGE: Years	Months	Days	If less than one day
	1	3 9 1	hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Brother Roberts
13. Birthplace Roan Co. N. Carolina

MOTHER
14. Maiden Name Hattie STATON
15. Birthplace Salton, N. Carolina

16 (c) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery Location AUG 12 1948

18 (a) Funeral director
(b) Address

19 (a) (Date filed by Registrar) (b)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-48 19 , at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to 8-8 1948, and that I last saw h[illegible] alive on 8-8 1948

Immediate cause of death Enteritis
Ingestion Lumbering over,
Enumerated Lesion (Syph)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. J. Lumbrazo Jr. M. D.
Address Univ. Hosp. Date signed 8-8-48

65833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 65833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Hilldale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Hilldale Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Meyer M. Hornstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ada Nee Levy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 12, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Kalman Hornstein
13. Birthplace Poland

MOTHER
14. Maiden Name Carrie Meyers
15 Birthplace Poland

16 (a) Informant Ada Hornstein
(b) Address 2821 Hilldale Ave

17 (a) Burial (b) Date thereof Aug 13, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received AUG 13 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1948 to 8/12 1948, and that I last saw him alive on 8/12 1948.

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/28/48

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed 8/14/48 M. D.

VS 15)

5834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G65834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Wilkens ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME J. Stuart Bond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Clara Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 18[illegible]

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Dyer
15. Birthplace Baltimore Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 8 13 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount
Location Baltimore Md.

18 (a) Funeral director H. B. Heath and Son
(b) Address 502 N. Calvert St.

19 (a) AUG 13 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 6:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/48 to 8/11/48 and that I last saw him alive on 8/10/48.

Immediate cause of death	Duration
CARDIAC FAILURE	
MYOCARDIAL INFARCTION	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. [illegible] M. D.
Address [illegible] Date signed 8/14/48

X

G65835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Towson
(d) Street No. 121 W. Susquehanna Avenue (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Anna Donahue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1904

8. AGE: Years 44 | Months 3 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Wife.

11. Industry or business

FATHER
12. Name: Michael Zuelta
13. Birthplace: Germany

MOTHER
14. Maiden Name: Hedwig Fleissner
15. Birthplace: Austria

16 (a) Informant: Mrs. Francis Smith
(b) Address: Montgomery Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory: St. John's
Location: Long Green, Md.

18 (a) Funeral director: Leonard J. Luck
(b) Address: 539 E. Hoffman St.

AUG 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1948, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/ 1948 to 8/12/ 1948 and that I last saw her alive on 8/12/48 19

Immediate cause of death: Respiratory failure

Due to: Cachexia

Due to: Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: December, 1947

Major findings of operation: Carcinoma of uterus.

of autopsy: Carcinomatosis.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Anthony F. DiPaula M. D.
Address: St. Joseph's Hosp. Date signed 8/12/48

VS 186

X

665836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 665836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural (Sykesville)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Gamber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	w. divorced

6 (b) Name of husband or wife Bertha Bearoft

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Finksburg Carroll Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George W Gamber
13. Birthplace Maryland

MOTHER
14. Maiden Name Christy ann Galston
15. Birthplace Maryland

16 (a) Informant Mrs Ethel Carr
(b) Address 65 W Belvedere ave Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 48 (month) (day) (year)

(c) Cemetery or crematory Calvary
Location Gamber Carroll Co. Md

18 (a) Funeral director Wm B Freymans Sons
(b) Address Reisterstown Md

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948 to Aug 11 1948 and that I last saw h[illegible] alive on Aug 11 19 48.

Immediate cause of death	Duration
Pneumonia + hypostatic pneumonia	
Due to Superior mesenteric vessels thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug 4, 1948

Major findings of operation: Major portion of small bowel gangrenous.

Of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. G. Martin M.D. M. D.
Address Maryland General Hosp. Date signed 8-11-48

VS 193

X

G65837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G65837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 No. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Baccuris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Jeanette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	1	27	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Shoe Repairman
11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15 Birthplace Poland

16 (a) Informant Mrs. Agatha Pugsley
(b) Address 228 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 14 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross National Catholic
Location Gorman Mill Road Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 10 1948 at 11: AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 10 1948 8 - 10 1948 and that I last saw h alive on 8 - 10 1948

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary arteriosclerosis	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Charles Krayfield M. D.
Address Union Memorial Hospital Date signed 8/10/48

VS 150

65838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d. & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Dunbrick Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lieut. John Henry Kratz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Widowed

6 (b) Name of husband or wife Anna Margaret Kratz

6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1861

8. AGE: Years 86 | Months 9 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None (Retired)

11. Industry or business Lieut. Police Dept

FATHER
12. Name Walter A. Kratz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Cook
15. Birthplace Germany

16 (a) Informant Mrs. Louise Munsinger
(b) Address 311 Dunbrick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/48 (month) (day) (year)

(c) Cemetery or crematory Carlwood Memorial Park
Location Relay Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Allen Ave Wilkinson Baltimore Md

19 (a) Aug 13 1948 (Registrar) (Registrant)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 12 1948, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 9 1948 to 8 - 12 1948 and that I last saw him alive on 8 - 12 1948

Immediate cause of death Uremia — Duration

Due to Benign prostatic hypertrophy & obstruction — Duration

Due to Arthritis & Neuritis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Dawson, M. D.
Address Date signed

VS 130

G65839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G65839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Fendall Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Fendall Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel DeLuca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Adolph DeLuca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benj. Allen
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Amelia Baumann
15. Birthplace Balto Md.

16 (a) Informant Mr. August DeLuca
(b) Address 3019 Fendall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 12.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1948 to Aug. 8 1948, and that I last saw h[illegible] alive on Aug 8, 1948.

Immediate cause of death Cerebral hemorrhage — Duration 10 min.

Due to

Due to

Other Conditions Diabetes mellitus — 30 yrs.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harper M. D.
Address 5201 Loryndale Ave Date signed Aug 11, 48

VS 150

83a

65840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ G65840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA
(c) Hospital or institution: MERCY HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALT
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6325 Hudson (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME James Poe Jr. (JAMES EMERY POE, JR.)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/11/46

8. AGE: Years 2 | Months 1 | Days | If less than one day hr. min.

9. Birthplace MORGAN TOWNS, W.Va. (Town, county, and state)

10. Usual Occupation NONE.

11. Industry or business

FATHER
12. Name James Poe
13. Birthplace GRAFTON, W.Va.

MOTHER
14. Maiden Name Helen SEMANICK
15. Birthplace GRAFTON, W.Va

16 (a) Informant Mr. James E. Poe - father
(b) Address 6325 Hudson Street -24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 (a) AUG 13 1948 (Date rec'd by local registrar) Huntington W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/48 1948 at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/11 1948
and that I last saw him alive on 8/11/48 19

Immediate cause of death	Duration
Acute Resp. Failure	
Due to Acute Lymph. Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Aquate M.D.
Address Emery Date signed 8/14/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 655841

655842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 S. Highland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 S. Highland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD FRANKLIN JENKINS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-01-9831

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Alice Lawton Jenkins
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1872

8. AGE: Years	Months	Days	If less than one day
75	9	29	hr. min.

9. Birthplace: A.A. County, Md. (Town, county, and state)
10. Usual Occupation: Engineer -1st. Grade
11. Industry or business: Sanitary Corp.

FATHER
12. Name: Wm. Jenkins
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? King
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice Lawton Jenkins
(b) Address: 39 S. Highland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/14/48 (month) (day) (year)
(c) Cemetery or crematory: Magothy Church Cemetery
Location: A.A. County, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b)
(Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1948 to Aug 10 1948 and that I last saw h[illegible] alive on Aug 10 1948

Immediate cause of death: Coronary Embolism
Due to: Arteriosclerosis
Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 6 weeks

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. A. Gracon, M. D.
Address: 617 North St. Date signed: 8/11/48

VS 180

X

G658842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G658842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 William St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADDIE MAY GISRIEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Edward C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 4 1884 Inquired

8. AGE: Years	Months	Days	If less than one day
63	9	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Joseph Simmons
13. Birthplace Md

MOTHER
14. Maiden Name Rhoda Tyson
15. Birthplace Md

16 (a) Informant Mr. Edward Gisriel
(b) Address 828 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/48 (month) (day) (year)
(c) Cemetery or crematory Hopewell
Location Bot Deposit Md

18 (a) Funeral director Harry H Witzke
(b) Address 1101 Edmondson Ave

AUG 13 1948 (Date filed) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948 at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1948, to August 12 1948, and that I last saw h[illegible] alive on August 12 1948.

Immediate cause of death Strangulated Femoral Hernia (Acute) Duration
Perforated & Gangrenous Peritonitis

Due to

Due to

Other Conditions Auricular Fibrillation & Marked Decompensation.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Inguinal

of autopsy Strangulated Femoral Hernia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan E. Gerardi M. D.
Address 1213 Light St. Date signed 8-12-48

VS 150

665843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 12 B

Registered No. 665843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Bank Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Bank Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK T. DROZD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) October 9, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Michael Drozd
13. Birthplace Poland

MOTHER
14. Maiden Name Rozalia Bogdan
15. Birthplace Poland

16 (a) Informant Mr. Joseph Drozd
(b) Address 305 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

AUG 13 1948 (Date rec'd by registrar) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Aug. 1948, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 July 1948 to 10 Aug 1948, and that I last saw him alive on 10 Aug 1948

Important cause of death	Duration
Respiratory failure	
Due to Pneumonia	2 da.
Due to	
Other Conditions Pulmonary Tbc. Intermittent hemoptysis.	yrs. ?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd
Address 2601 Eastern Ave Date signed 13/8/48 M. D.

VS 150

109 E1

G65844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G65844

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo. and 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 S. Albemarle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Pisano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	widower

6 (b) Name of wife late Adelina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	11	1		

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Seafarer
11. Industry or business

FATHER
12. Name Giuseppe Pisano
13. Birthplace Italy

MOTHER
14. Maiden Name Filippa Lanza
15. Birthplace Italy

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14 1948 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 322 S. High St.

19 (a) AUG 13 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 27 1947, to August 12 1948 and that I last saw him alive on Aug. 12 1948.

Immediate cause of death	Duration
Carcinoma of the bronchus with metastases to regional nodes and brain	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. van Ackeren, M.D.
Address Marine Hospital, Balto. Md. Date signed 8-12-48

VS 190

G65845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G665845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N. Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John E. Spence.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Sarah Spence 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1885

8. AGE: Years	Months	Days	If less than one day
63	4	21	hr. min.

9. Birthplace Snowhill, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Spence.
13. Birthplace Snowhill, Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Snowhill, Md.

16 (a) Informant Sarah Spence.
(b) Address 401 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Tate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] 13 [illegible] (Date rec'd by registrar) (b) Pennington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948 at 12:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10-47 19..., to 8-12, 1948. and that I last saw him alive on 8-11-1948.

Immediate cause of death Congestive Heart Failure — Duration 3 wks.
Due to Bronchopneumonia — 3 yrs
Due to Emphysema
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. M. Daniel M. D.
Address 807 N. Caroline Date signed 8-13-48

VR 100

X

85846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Diamond St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Diamond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Hart.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife Daniel Hart.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1906

8. AGE: Years	Months	Days	If less than one day
42	2	9	hr. min.

9. Birthplace Scranton, Penna. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name William Smith.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Emma -
15. Birthplace Penna.

16 (a) Informant Daniel Hart.
(b) Address 322 Diamond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13 1948 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 13 1948 (Date rec'd by registrar) Registrar

Funeral for Williams, Mr

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1948, to 8/10 1948, and that I last saw h[illegible] alive on 8/10 1948.

Immediate cause of death
Hypertensive Cardiovascular disease
Due to
Due to
Other Conditions Bedridden
Emaciation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 6 Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Garner M.D.
Address 753 Georges St Date signed 8/12/48

X

65847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G65847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Park Ave
(c) Hospital or institution:
St. Joseph's Home For The Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Napora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Maryanna

6 (c) If alive, give address Deceased

7. Birth date of deceased (mo., day, yr.) Unknown ?

8. AGE: Years	Months	Days	If less than one day
? 80 About			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jozef Napora
13. Birthplace Poland

MOTHER
14. Maiden Name Zofia Barnas
15. Birthplace Poland

16 (a) Informant Rose Budny (Daughter)
(b) Address 6913 Holabird Ave (Dundalk)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director Rose A Weber
(b) Address 705 South Ann Street

19 (a) AUG 13 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 1948, at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1948 to Aug. 12 1948, and that I last saw him alive on Aug. 12 1948

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	???
Due to	
Due to	
Other Conditions CHRONIC BRONCHITIS WITH ASTHMA (include pregnancy within 3 months of death)	1/7/45

Date of operation None

Major findings of operation:

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Dragon M. D.
Address 209 N. Chester St. Date signed 8/12/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G65848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius O. Bagent

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mannie Bagent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1885

8. AGE: Years 63 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace Hagerstown, Maryland
(Town, county, and state)

10. Usual Occupation Confectioner
11. Industry or business

FATHER
12. Name Jacob Bagent
13. Birthplace Unknown

MOTHER
14. Maiden Name Anna Andrews
15. Birthplace Unknown

16 (a) Informant Mrs. Mannie Bagent
(b) Address 1836 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Aves.

19 (Date rec'd by registrar) AUG 13 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-48 1948, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1948 to 8-12-48 1948, and that I last saw him alive on 8-12 1948.

	Duration
Immediate cause of death: Uremia	
Due to: Hypertensive Cardio-Vascular Arteriosclerotic Heart Disease	
Due to:	
Other Conditions: Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 7-3-48
Major findings of operation: Prostatic Hypertrophy
of autopsy: Arteriosclerosis, generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Bindeman M.D.
M. D.
Address W.B.G.H. Date signed 8-14-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G65849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G65849
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 E. Tunbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 E. Tunbridge Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. CHAPMAN

3 (b) If veteran, name war: None

3 (c) Social Security Account No.?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Susie R. Chapman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1860

8. AGE: Years 88 | Months 0 | Days 26 | If less than one day: hr. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Chapman
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Susie R. Chapman
(b) Address 507 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Spring Hill
Location Easton, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 1?

19 (a) AUG 13 1948 (b) Huntington Williams
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1948 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1948 to Aug. 11 1948.
and that I last saw him alive on Aug 11 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl H. Beran, M.D.
M. D.
Address 5111 York Rd Date signed Aug 13, 1948

VS 150

G65850 ✓ G65850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME MARY MARGARET JENNINGS

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Andrew F. Jennings
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr) Oct. 8, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	10	4		865

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Gephardt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Trunk
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hazel M. Smith - daughter
(b) Address 129 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

(a) [illegible] (b) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12th 1948 at 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17th 1948 to Aug 11th 1948 and that I last saw h alive on Aug 11th 1948.

Immediate cause of death Intracranial Hemorrhage — Duration 3 days

Due to Carcinoma — 2

Due to _____

Other Conditions _____
(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury _____

23. Signature H. J. Taylor M. D.
Address 100 N. Mallory Date signed 8/13/48

VS 130

G65851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Schlag XV G65851

95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Funeral Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt #15 Box 193 Beaver (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (b) FULL NAME Marie Schlag

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Ewald
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/8/84
8. AGE: Years 64 Months 7 Days 9 If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Nicholas Birchukow
13. Birthplace Russia
14. Maiden Name Fienke
15. Birthplace Hamburg, Germany

16 (a) Informant Ewald Schlag - husband
(b) Address Route 15, Box 193, Balto-20-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

(a) Date received by registrar [illegible] (b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1948 to 8/11 1948, and that I last saw her alive on 8/10 1948.

Immediate cause of death: Cardiac failure — Duration
Due to: Coronal occlusion
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Charles Slagle M.D.
Address Maryland Square Date signed 8/14/48

G65852 BALTIMORE CITY HEALTH DEPARTMENT G65852

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Holbrook St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Holbrook St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Leo Callender
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Jessie M. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1898

8. AGE: Years	Months	Days	If less than one day
49	10	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business Consolidated Eng. Co.

MOTHER / FATHER
12. Name Wm. E. Callender
13. Birthplace Balto. Md.
14. Maiden Name Laura E. Martin
15. Birthplace Balto. Md.

16 (a) Informant Jessie M. Callender (wife)
(b) Address 1222 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

(a) 8-13-1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/48 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Aug 12 1948, and that I last saw h[illegible] alive on Aug 12 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Chas. Paul M. D.
Address Dr. Local Institution Date signed

VS 150

Col. G65853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 C

G65853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 S. Matthew St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Brandon

3 (b) If veteran, name war C
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Sep

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-98

8. AGE: Years	Months	Days	If less than one day
50	1	15	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER 12. Name James Brandon
13. Birthplace ?

MOTHER 14. Maiden Name Nancy Bubbel
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location Baltimore Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1119 Bolton St

19 (a) (Date Rec'd) (b) Registrar

AUG 18 Washington MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 12 1948 19 at 12.05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948 to 8-12 1948 and that I last saw him alive on 8-12 1948.

Immediate cause of death Cerebro-Vascular accident — Duration 24hrs

Due to Syphilis-meningovascular Arteriosclerosis

Due to

Other Conditions Hypertensive Cardio Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12 Aug 48

G65854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G65854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home + Hospital
(c) Hospital or institution:
Broadway + Fairmount Ave.
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~) 17 yrs
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 S. Caroy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Backhaus, Mr. Albert

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-10-2576

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Martha Backhaus

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 14. 1879

8. AGE: Years 68 | Months 11 | Days 28 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Mgr. Restaurant

11. Industry or business Restaurant

FATHER
12. Name Backhaus, Mr. Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Kin Weisenborn
15. Birthplace Germany

16 (a) Informant Mrs. Albert Backhaus
(b) Address 1421 S. Caroy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16. 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. + Mrs. Conn R. Teufelsdorf
(b) Address 5311 Edmondson Ave.

19 (a) [illegible] (b) Mountain for Williams

(To be filled in by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1948 at 7 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1948 to 8-12 1948 and that I last saw him alive on 8-12 1948.

Immediate cause of death Cardio-resp. failure.

Duration: 15 hrs.

Due to Atalectasis, left

Due to Atalectasis + partial pneumo thorax, L.

Other Conditions C.A. resection Ca esophagus

(Include pregnancy within 3 months of death)

Date of operation 8-10-48

Major findings of operation: Ca of esophagus

of autopsy: confirmed above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Robert Haase M. D.
Address Church Home + Hosp. Date signed 8-12-48

VS 150

F. Robert Haase

G658855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G658855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da's
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. LAWSON

3 (b) If veteran, name war **

3 (c) Social Security Account No. 219-20-9522

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jane R. Lawson

6 (c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): Jan. 13 1884

8. AGE: Years 64 | Months 6 | Days 29 | If less than one day ******** hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Merchant - Retired

11. Industry or business

FATHER
12. Name: George S. Lawson
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Susan Tyson Harvey
15. Birthplace: Maryland

16 (a) Informant: S. Howard Lawson (son)
(b) Address: 114 S. Kossuth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 14/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: F.B. WIPPERT & SON
(b) Address: 1300 EUTAW PLACE..17

(c) Filed 1948 Thorlington Williams Registrar
Rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11th 1948, at 3:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8. 1948 to Aug. 11 1948 and that I last saw him alive on Aug. 11 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Shaw M. D.
Address St. Agnes Hosp. Date signed 8/11/48

VS 150

DR. JOHN H. SHAW. M.D.

356

BALTIMORE CITY HEALTH DEPARTMENT ✓ 665856
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 N.
(c) Hospital or institution: Balto City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Lemmon St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Evatt "John J. Evatt Hgs" Evatt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1880

8. AGE: Years	Months	Days	If less than one day
68	5	20	19 hr. min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business B. & O. R. R.

FATHER
12. Name George R. Evatt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth McCarthy
15. Birthplace Baltimore Md

16 (a) Informant Virginia E. Rodgers
(b) Address 1910 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director J. B. Hubbard & Son
(b) Address 1300 Eutaw Place
Huntington Williams M.D.

AUG 1948
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 11:27 A M

21. I certify that I took charge of the remains described above, held an Autopsy on Inspection thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Truhardt M.D.
Medical Examiner.
Date signed 8/11/48

G65857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G65857 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Yorkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Brown (Also, William A. Reese)

3 (b) If veteran, name war: WW #1
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1893
8. AGE: Years 54 | Months 10 | Days 16 | If less than one day: hr. min.
9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Seafarer
11. Industry or business

FATHER
12. Name John Brown (Reese)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Josephine Simons
15. Birthplace Pennsylvania

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1948 to Aug. 12 1948, and that I last saw him alive on Aug 12 1948.

Immediate cause of death: 1-Hypertensive cardiovascular disease with cardiac insufficiency — Duration: unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature [signature] M. D.
Address Marine Hospital, Baltimore, Md. Date signed 8-12-48

VS 199

G65858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

G65858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mths
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5216 Gowan Ave #12 CROWSON (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James J. Sweeney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/10/1860

8. AGE: Years	Months	Days	If less than one day
88	1	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Sweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGee
15. Birthplace Ireland

16 (a) Informant John M. Buchanan M.D.
(b) Address Mercy Hospital

17 (a) Burial, cremation, or removal Burial (b) Date thereof (month) 8 (day) 14 (year) 48
(c) Cemetery or crematory St. Mary's - Govans
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

AUG 13 1948 (Date received by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1948 to Aug 11 1948, and that I last saw him alive on Aug 11 1948.

Immediate cause of death Heart failure
Due to Acute Bladder Infection
Due to Acute Non-function of Kidneys
Due to Bronchial Pneumonia
Other Conditions Probable ruptured bladder

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Buchanan M. D.
Address Mercy Hospital Date signed 8-11-48

VS 150

665859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1630

665859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest P. Weil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife MARGUERITE B. WEIL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 44 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business

FATHER
12. Name JOHN C. WEIL
13. Birthplace (?)

MOTHER
14. Maiden Name IRENE STRITHOFF
15. Birthplace Balto., Co.

16 (a) Informant MRS. MARGUERITE B. WEIL
(b) Address 2916 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT & 22ND

19 (a) AUG 13 1948 (Date received by registrar) (b) Huntington, Hollins, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbital Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-48 at P.M.
(b) Where did injury occur? 2916 Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) no
(d) Means of injury Ingestion of Barbital tablets

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-12-48

G65860 BALTIMORE CITY HEALTH DEPARTMENT G65860
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dunmore St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 821 W. Lanvale St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Elizabeth James McCoy

3 (b) If veteran, name war None | 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/20

8. AGE: Years 28 | Months 7 | Days 26 | If less than one day — hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housemaid
11. Industry or business None

FATHER 12. Name William Milton
13. Birthplace Balto, Md.

MOTHER 14. Maiden Name Florence Royston
15. Birthplace Balto Md

16 (a) Informant E. Mason Friend
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County Md

18 (a) Funeral director Mrs Rosa L. Winston
(b) Address 1129 N. Carrollton

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1948 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1948 to 8-10 1948 and that I last saw h She alive on 8-10 1948

Immediate cause of death
Pneumonia Bronchopneumonia
Due to Lung Abscess
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: 8-11-48 - Sh

Duration
48 hrs
6 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Walbert St Date signed 8-13-48

AUG 1
VS 150

65861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G65861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4912 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony, Eva L.

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Roger A. Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16th 1898

8. AGE: Years 50 Months 2 Days 27 If less than one day hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Charles Warner
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Anna Shelton
15. Birthplace Frederick Md.

16 (a) Informant Roger A. Anthony
(b) Address 4912 Reisterstown Rd.

17 (a) Burial (b) Date thereof 8/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Johnsville
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1312 St. Paul St.

19 (a) AUG 14 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 13 - 1948 at 1140 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1948 to 8-13 1948, and that I last saw her alive on 8-13 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Thyrotoxic Heart Disease

Due to Toxic nodular goitre

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David L. Silverstein M. D.
Address West Balto. Gen'l Hosp. Date signed 8/13/48

VS 190

G65862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE #12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6307 PINEHURST RD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL G. BALLARD
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: LILLIAN HICKS BALLARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 18, 1890
8. AGE: Years 58 | Months 3 | Days 26 | If less than one day hr. min.
9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation ATTORNEY
11. Industry or business —

FATHER
12. Name WILLIAM C. BALLARD
13. Birthplace CHRISTFIELD, MD

MOTHER
14. Maiden Name ROBERTA FRANKLIN
15. Birthplace MARYLAND

16 (a) Informant LILLIAN HICKS BALLARD (WIFE)
(b) Address SAME AS DECEASED

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 2021 Eutaw Ave.

19 (a) AUG 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 AUGUST 1948, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11:15 AM 13 AUG 48 to 1:15 PM 13 AUG 48 19; that I last saw him alive on 13 AUG 1948.

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day.
Due to: Cerebral hemorrhage — 1½ days
Due to: Hypertension — ? years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: 8/13/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald J. England M. D.
Address Maryland General Hosp. Balto. Md. Date signed 13 Aug 48

VII 193

X

665863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G665863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 240-12-7726

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/1914

8. AGE: Years 34 | Months 4 | Days 28 | If less than one day - hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Young
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Holden
15. Birthplace N.C.

16 (a) Informant Lucy Stewart (Mother)
(b) Address R.F.D. Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Charles T. Cooper
(b) Address 518 Carrollton Ave.

19 AUG 14 1948 (Date rec'd by registrar) Thurlow Tee Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1948, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pontechial hemorrhage of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-5-48 at 9:10 17:30 P.M.
(b) Where did injury occur? Milbury & Myrtle Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? not
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Kay M.D. Medical Examiner.
Date signed 8-6-48

VS 181

G665864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G665864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elijah Grimes. (GRIMES)

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Fate

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 1858

8. AGE: Years	Months	Days	If less than one day
90			..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name UNKNOWN
13. Birthplace .....

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace .....

16 (a) Informant Dept. Public Welfare
(b) Address 328 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48. (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6th 1948, at 3.20 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29th 19.. to Aug 5th 1948. and that I last saw him alive on Aug 5 1948.

Immediate cause of death	Duration
Marasmus	
Due to Old age	
Due to	
Other Conditions Hypertension	4 years.

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Charles Grimes M. D.
Address 910 Maryland St. Date signed Aug. 11

VS 150

162 C 1948.

G65865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G65865

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 794 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST Richard (Fox) FAX

3 (b) If veteran, name war: World War #I.

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: COLORED

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1898

8. AGE: Years 50 | Months 7 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Waiter

11. Industry or business

FATHER
12. Name: Richard Fax
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Alice Ruff
15. Birthplace: Maryland.

16 (a) Informant: Eugene Fax
(b) Address: 794 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md.

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Penna. Ave. Huntington Woll Mt, Md.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 3.30 P M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased died to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed

65866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 65866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1871

8. AGE: Years	Months	Days	If less than one day
77	-	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired Tailor
11. Industry or business

FATHER
12. Name John F. White
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Callan
15. Birthplace Ireland

16 (a) Informant Miss Julia White
(b) Address 5 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry Ellmann
(b) Address 4204 Ridgewood Ave

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/48 19 , at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15/48 19 8/14/48 19 , and that I last saw him alive on 8/14/48 19

Immediate cause of death	Duration
Hypertrophy of the prostate with urinary retention.	3 yrs.
Due to	
Due to	
Other Conditions Arteriosclerotic C-V disease	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Vernon Williamson M. D.
Address 4508 Edmondson Ave Date signed 8-14-48

VS 150

Balto 29

139a

G65867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G65867
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN MONITOR FOUNTAIN

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Charles E. F. Fountain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 17, 1862

8. AGE: Years	Months	Days	If less than one day
86	6	24	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John B. Herold
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Hahn
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anna E. Kunnecke
(b) Address 3009 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery ~~Loudon Park~~ Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICHNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 14 1948 (Date rec'd by local registrar) [illegible] REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Past 20 years 19 to 19; and that I last saw her alive on Aug 11 1948

Immediate cause of death Carcinomatosis — Duration 1 yr

Due to Ca. of breast

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Med Arts Date signed 8/14/48

VS 150

X

G655868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G655868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Adelle Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Adelle Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora A. Mitchell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Mitchell
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Dec. 8, 1860

8. AGE: Years 87 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Jacob Brandt
13. Birthplace: France

MOTHER
14. Maiden Name: Martha Britten
15. Birthplace: South Carolina

16 (a) Informant: Mrs. George Newlin
(b) Address: 4403 Adelle Terrace - Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 15 1948 (month) (day) (year)
(c) Cemetery or crematory: Washington Park
Location: Indianapolis, Indiana

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Huntington, Indiana, Mch 8 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948, at 2.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1948 to Aug. 14 1948 and that I last saw her alive on Aug. 14 1948.

Immediate cause of death: Congestive Heart Failure — Duration 3 wks.

Due to Arteriosclerotic Cardiovascular Renal Disease — 10 yrs (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nelson K. Talbert M.D. M. D.
Address Catonsville 28, Md. Date signed 8-14-48

VS 150

G65869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G65869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Ocala Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Ocala Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Zalis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: House Wife
11. Industry or business

FATHER: 12. Name Abraham Kleiman
13. Birthplace Russia

MOTHER: 14. Maiden Name Dina Lashbitz
15. Birthplace Russia

16 (a) Informant Samuel Zalis
(b) Address 2305 Ocala Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Signature of registrar) by Huntington Williams M.D.
(b) Date received AUG 15 1948

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1948 to Aug 14 1948 and that I last saw h[illegible] alive on Aug 14 1948.

Immediate cause of death: Coronary Occlusion — Duration 2 days

Due to Hypertensive Cardio-Vascular Disease — 4 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Henry Glassman M. D
Address 707 Madison Ave Date signed Aug 14 48

G65870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65870 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4903 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Greenberg

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Myers
15. Birthplace Russia

16 (a) Informant Leon Greenberg
(b) Address 1610 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Rt 40 & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 6100 Eutaw Place

AUG 15 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1948 at 9:39 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory Failure

Due to Cardiac Decompensation

Other Conditions Hypertension C.V.D.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner
Date signed 8-13-48

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G65871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 2a

G65871
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (If not in hospital) 4506 Frederick Ave
(c) Hospital or institution: Conrad Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rubin Katzewitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Jennie Katzewitz
(b) Address 3913 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19. (a) [illegible] (b) Registered by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1948 at 7:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8-6 1948 to 8-13 1948 and that I last saw him alive on 8-13 1948

Immediate cause of death Cerebral hemorrhage — Duration about 2 hrs

Due to Cerebral Arteriosclerosis and Hypertension — Many years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Zeitelbaum M.D.
Address 1801 Eutaw Pl.
Date signed 8/13/48

G65872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45F

Registered No. G65872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL J KEELEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Katherine Keeley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3 [illegible]

8. AGE: Years 65 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Yard on Ships

FATHER
12. Name Peter Keeley
13. Birthplace Ireland

MOTHER
14. Maiden Name Hanora
15. Birthplace Ireland

16 (a) Informant Ella M. Keeley
(b) Address 3102 Keeleys Ln

17 (a) Burial (b) Date thereof Aug 17 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvert
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 Baltimore St

AUG 16 1948
(Date rec'd by registrar) [illegible]

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948, at 4:10 M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of throat.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8-14-48

G65873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. G65873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4611 Schenley Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Schenley Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carl W. Meislahn (CARL WALTER MEISLAHN)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-20-8000

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Erma Krug Meislahn
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb-24-1885

8. AGE: Years 63 | Months 5 | Days 21 | If less than one day: hr. 20 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Architectual Examiner for
11. Industry or business F.H.A.

FATHER
12. Name Charles F. Meislahn
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Dogge
15. Birthplace Germany

16 (a) Informant Mrs. Erma K. Meislahn (wife)
(b) Address 4611 Schenley Road.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug-16-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108-W-North-Ave.

AUG 15 1948 (Date rec'd by registrar) (b) Huntington Hilliard M.D. Registrar

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 14/48 9 at 8:25 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 13, 1948 at 4:00 P. M.
(b) Where did injury occur? Garage- rear of residence
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? No
(d) Means of injury Motor exhaust

23. Signature E. L. [illegible] M.D.
Medical Examiner.
Date signed Aug. 14/48

679524

G65874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

G65874 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Brunt Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Harris Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Negro

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1947

8. AGE: Years 1 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Lewis Harris Sr.

13. Birthplace Bethune, S.C.

MOTHER 14. Maiden Name Virgie Smallwood

15. Birthplace Baltimore, Md.

16 (a) Informant Lewis Harris Sr.

(b) Address 516 Brunt Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1948 (Month) (Day) (Year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home

(b) Address 609 Druid Hill Ave.

19 (a) (Date received by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection
Fecal impaction
Malnutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While working?
(d) Means of injury

23. Signature Emil L Rogy M.D.
Medical Examiner.

Date signed Aug. 14/48

G65875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G65875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Patterson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 706-07-4981

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Geneva Coates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1913

8. AGE: Years	Months	Days	If less than one day: hr.	min.
34	7	22		

9. Birthplace Ho Venia, Balto Co. Md. (Town, county, and state)

10. Usual Occupation Brick molder

11. Industry or business

FATHER
12. Name George M. Patterson Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Lettie Page
15. Birthplace Balto Md.

16 (a) Informant Mrs. Geneva Coates Patterson
(b) Address 1649 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1948
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1601 Druid Hill Ave.

19 (a) 1948 (b) Date rec'd by registrar Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH August 13, 1948, at 7:05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Thrombosed aneurysm of coronary artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George T. Merrill M.D.
Medical Examiner.
Date signed 8/14/48

VS 151

Farber ✓

G65876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G65876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 2 17
(e) Length of stay in Baltimore (yrs., mos., or days) All life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Forbes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife Wm. Forbes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	4	6		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business —

FATHER
12. Name Lorenzo Buchanan
13. Birthplace Maryland

MOTHER
14. Maiden Name (unknown) Dutton
15. Birthplace Maryland

16 (a) Informant Mrs. Jennie Garrett
(b) Address 1302 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. (month) (day) 19 (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 601 Druid Hill Ave.

AUG 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1948, at 8⁴⁵ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1948, to 8-13 1948, and that I last saw h~~er~~ alive on 8-13 1948.

	Duration
Immediate cause of death Respiratory paralysis	
Due to Carcinoma - common bile duct	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma common bile duct
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Evans M. D.
Address Univ. Hosp. Date signed 8-14-48

VS 150

X

G65877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G65877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 David Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ernest A. Brooks.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ELLEN D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 6, 1896

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)

10. Usual Occupation Dyer and Cleaner

11. Industry or business

FATHER
12. Name GEORGE BROOKS
13. Birthplace EASTON, MD.

MOTHER
14. Maiden Name JULIA CLAYTON
15. Birthplace BALTO. MD.

16 (a) Informant MRS. ELLEN A. BROOKS
(b) Address 2109 DRUID HILL AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN
Location BALTIMORE, Md.

18 (a) Funeral director Geo. A. Hallowell
(b) Address 1631 Druid Hill Ave.

19 Aug 15 1948 (b) [illegible] Baltimore Md. Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1948 at 9:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1948 to 8/13 1948 and that I last saw him alive on 8/12 1948.

Immediate cause of death: UREMIA — Duration: 4 dys.

Due to: Hypertensive C-V Renal Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X. Preston Stuart, M.D.
Address 661 N. Carrollton Date signed 8/13/48

VS 150

G65878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G65878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lanvale St.
No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-4294

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Henrietta J. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1879

8. AGE: Years	Months	Days	If less than one day
69		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Landryman
11. Industry or business

FATHER
12. Name Luther Martin
13. Birthplace Easton, Maryland.

MOTHER
14. Maiden Name Ellen Stokley
15. Birthplace Providence, R.I.

16 (a) Informant Mrs. Henrietta J. Martin
(b) Address 515 W. anvale Street

17 (a) Burial (b) Date thereof 8/15/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-10 1948 at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1948 to 8/10 1948 and that I last saw h[illegible] alive on 8/10 1948.

Immediate cause of death Cerebral Hemmorrhage (1 Day)

Due to arteriosclerosis

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1111 Seel W Date signed 8/11/48

VS 150

G65879

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65879 Registered No.

CERTIFICATE OF DEATH 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St—
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Engelbert Frhlik

3 (b) If veteran, name war / **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	W.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25, 1875

8. AGE: Years	Months	Days	If less than one day
72 73	11	18	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adolph Frhlik
13. Birthplace

MOTHER
14. Maiden Name Cash. —
15. Birthplace

16 (a) Informant Sister Linus [illegible]
(b) Address 1200 Valley St—

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Signature of person who c'd by registrar) (b) Registrar

~~16 1948~~

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1948, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1948 to Aug. 12 1948, and that I last saw him alive on Aug. 11 1948.

Immediate cause of death	Duration
Valvular Heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Aurel Fiskus M. D.
Address 1873 N. Market St. Date signed 8/13/48

G65880 ✓ G65880

C.No. 12028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 W. Saratoga ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Percy Bernard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 4 - 1893

8. AGE: Years	Months	Days	If less than one day
54	9	8	hr. min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Bernard
13. Birthplace N.J.

MOTHER
14. Maiden Name Mamie ?
15. Birthplace N.J.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 / 18 / 48 (month) (day) (year)
(c) Cemetery or crematory Newark
Location Newark, N. J.

18 (a) Funeral director Dashiell R. Woodley
(b) Address 107½ Bloomfield Ave. Newton for Williams, Mgr.

AUG 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 12- 1948, at 5.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 4- 1948 to 8- 12- 1948 and that I last saw him alive on 8- 12- 1948

Immediate cause of death ?

Due to Pulmonary tuberculosis (?)

Duration ? yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton
Address Baltimore City Hospitals Date signed 8/14/48

VS 159

G65881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or instt. (yrs., mos., or days) 4 hrs 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 Pollock St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown. (MAY)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Fe
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1898
8. AGE: Years 70 | Months ? | Days ? | if less than one day hr. min.
9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation House Keeper.
11. Industry or business

FATHER
12. Name Timothy Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Kirby
15. Birthplace Ire

16 (a) Informant Mrs John McConnick
(b) Address 116 S. Calhoun St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/98 (month) (day) (year)
(c) Cemetery or crematory H. Rest Cem.
Location Balto. Md
18 (a) Funeral director Geo. E. Boyd Jr.
(b) Address 512 Hollins St.
19 (a) Filed AUG 15 1898 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13- 1898, at 2.35 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-98 to 8-13-1898, and that I last saw her alive on 8-13 1898.

Immediate cause of death: cerebro-vascular accident — Duration: unk.
Due to: hypertensive heart disease — unk.
Due to:
Other Conditions: cardiac decompensation, moderate — unk.
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman V. Uhler. M. D.
Address Franklin Sq. Hosp. Date signed 13 Aug 98

(Norman V. Uhler X)

VS 130

65882

BC-C 3647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

78B

Registered No. C65882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Redwood Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro.	Single

6 (b) Name of husband or wife: none.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
2½.			hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation infant
11. Industry or business 0

FATHER
12. Name James Johnson.
13. Birthplace Timmonsville. S.C.

MOTHER
14. Maiden Name Bessie Brown
15. Birthplace Timmonsville S.C.

16 (a) Informant James Johnson.
(b) Address 1102 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port, Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 AUG 16 1948 Huntington Williams Mgr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948 at 5:10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948, to Aug 14 1948, and that I last saw him alive on Aug 14 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Lead encephalitis	
Due to	
Other Conditions pneumonia right base. (Include pregnancy within 3 months of death)	over

Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Patterson Mack (M. D.)
Address University Hospital Balto - Maryland. Date signed 8-14-48

VS 190

665883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 665883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. General Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Cereal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Daniel Kasuba Dominic Kaszubinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215077091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lottie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
57				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Davidson Chem. Co.

FATHER
12. Name John
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Lottie Kaszubinski
(b) Address 1621 Cereal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A.Co.
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 14, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 13 1948 to AUGUST 14 1948 and that I last saw him alive on AUGUST 14 1948

Immediate cause of death	Duration
MASSIVE CEREBRAL HEMORRHAGE	
Due to CEREBRAL SCLEROSIS	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel P. Scalia
Address South Baltimore Gen. Hosp. Date signed 8/14/48

VS 150

G65884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G65884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State [redacted] MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4131 Mayx Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PEARLE A. SEELYE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife Henry E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 10-1877

8. AGE: Years	Months	Days	If less than one day
70	9	4	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Henry Austin
13. Birthplace Erie, Penna.

MOTHER
14. Maiden Name Sally Rice
15. Birthplace Kentucky

16 (a) Informant Mrs. Lois Y. Williams
(b) Address 915 Cator Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto
18 (a) Funeral director L. D. Luck
(b) Address 5305 Mayford Rd.
19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 14 1948 at 1 10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8 July 1948 to 14 Aug 1948 and that I last saw HER alive on 14 Aug 1948.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cachexia	
Due to Widespread Abdominal Carcinomatosis	
Other Conditions Primary site undetermined	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
Epidermoid abdominal carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Donald L England
Address Maryland General Hospital Date signed 14 Aug 48

VS 150

G665885

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G665885

Registered No. 518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto., Md. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Harview Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry John Schwartz

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lottie Burdette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 22, 1892

8. AGE: Years	Months	Days	If less than one day
56	1	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Meat Salesman
11. Industry or business

FATHER
12. Name William Schwartz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Bien
15 Birthplace Baltimore, Md.

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto. Md.

17 (a) Burial (b) Date thereof 8/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bals National
Location Balto
18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd
19 AUG 16 1948 (b) Huntington Hillen Registrar
(Date rec'd by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1948 to August 13 1948, and that I last saw him alive on August 13 1948.

Immediate cause of death Metastatic adenocarcinoma, lymph nodes, retroperitoneal, mediastinal, supraclavicular region, and adrenal glands, vertebral column; — Duration
Due to primary site probably prostate gland — 3 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury J. F. VAN ACKEREN

23. Signature [signature] M. D.
Address Marine Hospital, Balto Date signed 8-13-48

X

Dr. Hasse
G65886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G65886
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Overland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Overland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET IRENE CZARNOWSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Herbert Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21. 1885

8. AGE: Years	Months	Days	If less than one day
62	9	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Soistmann
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Ficke
15. Birthplace Md.

16 (a) Informant Mr. Francis Czarnowsky
(b) Address 2709 Overland Avenue 14

17 (a) Burial (b) Date thereof 8-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 15 19[illegible] Washington [illegible], Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1948 at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948, to Aug. 12 1948, and that I last saw her alive on Aug. 11 1948.

Immediate cause of death Uremia — Duration 9 hrs.

Due to Ca. of the Cervix c Deep pelvic infiltrations and ureteral obstruction Cachexia

Other Conditions Extreme Cachexia and emaciation

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Biopsy, Radium and Deep X-ray therapy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Henry Hasse M.D.
(M. D.)
Address 4718 Harford Rd. Date signed 8/13/48

VS 130

G65837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G65887
Registered No.

A64321 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Alice ANNA St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Erauth ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-41

8. AGE: Years	Months	Days	If less than one day hr.	min.
6	7	19		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Erauth
13. Birthplace Md.

MOTHER
14. Maiden Name Stella Sobus
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 So. Ann St

19 (a) AUG 16 1948 (Date received by Registrar) (b) Huntington Nathanson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-14- 1948 at 1-55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-1948 to 8-14 1948 and that I last saw him alive on 8-13 1948

Immediate cause of death: Convulsions — cerebral injury
Due to Tetanus
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 7-22-48 Tracheotomy
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature A. C. Fong M D
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

X

665888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

665888 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 E. Carey St.
(c) Hospital or institution:
Good Samaritan Home 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. High St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Younger or Oliver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife late Charles Younger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31 1877

8. AGE: Years	Months	Days	If less than one day
70	7	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Oliver
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Duffy
15. Birthplace Baltimore Md

16 (a) Informant Margaret Cherigo
(b) Address 312 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dallalana
(b) Address 2[illegible] S. High St.

19 (Date rec'd by registrar) AUG 16 1948 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6/48 19 to 19 ; and that I last saw him alive on 8/6 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Trumpet M.D.
Address 628 E. N. Ave. Date signed 8/15/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G65889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 Abbott Court
(c) Hospital or institution: 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Abbott Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Dorsey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1886

8. AGE: Years 61 | Months 11 | Days 25 | If less than one day ########## min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER
12. Name James W. Dorsey
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Miss. Margaret J. Dorsey
(b) Address 927 Abbott Court, Balto: Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) AUG. 16 1948 (b) Huntingtor Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th, 19 48 at 5.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 19 48 to Aug. 12 19 48
and that I last saw h alive on Aug. 12, 19 48

Immediate cause of death Hypertensive Cardio-Vascular Disease.

Duration 13 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Summerville
Address Medical Arts Bldg. Date signed 8/16/48

V S 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N.Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Alphonse Hentschel (Alphonse J.Hentschel)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 215-09-7103

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Anna Hentschel (Anna M.Weipert)

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) Jan 2 1896

8. AGE: Years (52) 52 | Months 6 | Days 23 | If less than one day ########## min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Mechanist

11. Industry or business American Can Co.

FATHER
12. Name Paul Hentschel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rolle
15. Birthplace Germany

16 (a) Informant Mrs.Anna M.Hentschel (Wife)
(b) Address 1620 E.Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue,Balto:Md.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948, at 9:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1948 to 8/14 1948 and that I last saw h alive on 8/14 1948.

Immediate cause of death: Cardiac failure — Duration
Coronary Thrombosis
Due to Uraemia, Decompensation
Due to H.B.P.D.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Wm. Funke M. D.
Address Church Home Date signed 8/14/48

VS 153

65891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓

G65891 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 E Lanvale St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1428 E Lanvale St. 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Joesting (Bertha R. Joesting)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles F. Joesting

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day: ~~hr.~~ ~~min.~~

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Dukehart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachel Young
15. Birthplace Baltimore, Md.

16 (a) Informant William R. Dukehart
(b) Address 1428 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1948, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory Failure

Due to Coronary Heart Disease

Other Conditions Cirrhosis Generalized

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert B. Madden M.D. Medical Examiner.

Date signed 8-15-48

VS 181

X

5892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. 65892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution:
Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Weldon Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Kalbfus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary Kalbfus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 7, 1861

8. AGE: Years	Months	Days	If less than one day
86	11	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation Fireman Union Trust Co.
11. Industry or business Retired 20 years

FATHER
12. Name John Kalbfus
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Ann Stites
15. Birthplace Maryland

16 (a) Informant Mrs. Katie E. Dosh
(b) Address 1325 Weldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) AUG 16 1948 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1941 to July 14 1945. and that I last saw h alive on

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic Cardiovascular Disease — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Kerrmann M. D.
Address 200 E. Fayette St. Date signed 8/16/48

G65893

GH. 110822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G65893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Ainquith ST. Z 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Lightner or Annie Leightner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1876

8. AGE: Years 72 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Brown
13. Birthplace S.C.

MOTHER
14. Maiden Name Alice Glayden
15. Birthplace S.C.

16 (a) Informant records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-48 (month) (day) (year)
(c) Cemetery or crematory Secrest Parken Park Cem.
Location Westminster S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address Lord Baltimore Hotel

AUG 16 1948 (Date rec'd by registrar) Washington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 12- 1948, at 6.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 21 -1947 to 8- 12- 1948, and that I last saw her alive on 8- 12- 1948

Immediate cause of death MD Drive Pulmonary Hemorrhage — Duration 15 min.

Due to Far advanced Pulmonary Tuberculosis & Laryngeal-Bilateral — Duration 18 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy none

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Balto. City Hospitals Date signed 8-13-48

VS 193

G65894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G65894
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution: Bon Secours Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Bond St., Balto, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Anna Rogalski Puncochar PUNCOCHAR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frank Puncochar
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr) April 5, 1913

8. AGE: Years 35 | Months 4 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Vincent Rogalski
13. Birthplace Poland

MOTHER 14. Maiden Name Teresa Dabrunek
15. Birthplace Czechoslovakia

16 (a) Informant Frank Puncochar
(b) Address 1602 Bond St., Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Date received by registrar Aug 16 48 (b) Registrar Lexington Hill M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1948 at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1948, to Aug. 14 1948, and that I last saw her alive on Aug. 14 1948.

Immediate cause of death Bilemia → Duration 6 wks.?

Due to Hepatic cirhosis Duration 6 mo.?

or

Due to Cancer of the pancreas Duration 6 mo.?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger, M. D.
Address Bon Secours Hospital Date signed Aug 14, 1948.

X

G65895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G65895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Burgundy St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) about 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Stella Louise E. Woodall

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William B. Woodall

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.) May 9, 1887

8. AGE: Years 61 | Months 3 | Days 6 | If less than one day ... min.

9. Birthplace Ottawa, Ontario Prov. Canada (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Joseph Billyard
13. Birthplace Canada

MOTHER
14. Maiden Name Mitchell (?)
15. Birthplace Canada

16 (a) Informant Wm. B. Woodall (Husband)
(b) Address 1128 Burgundy St. Balto. 30, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug. 18-1948 (month) (day) (year)

(c) Cemetery or crematory London Park, Balto, Md.
Location Edmondson Ave.

18 (a) Funeral director 1400 N. Charles St. Balto 3, Md.

(b) Address

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. 15 August 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to —

Other Conditions Fracture, old, left hip

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

Means of injury

23. Signature Wm. H. Kammerer, Jr. M.D. Medical Examiner.

Date signed 15 Aug. 48

G65896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65896
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Gwynn Falls Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Gwynn's Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine C. Blank

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11 1871

8. AGE: Years	Months	Days	If less than one day
76	9	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Blank
13. Birthplace Germany

MOTHER
14. Maiden Name Rose A. Eyle
15. Birthplace Germany

16 (a) Informant Miss Josephine Blank
(b) Address 3218 Gwynn's Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Rippon & Fleming
(b) Address 1476 Light St.

AUG 16 1948 (b) [illegible]
(Date received by registrar) Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1948, at 11 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Aug 13 1948, and that I last saw h[illegible] alive on Aug 13 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 min.
Due to Hypertensive Cardio-Vascular disease	10 yrs.
Due to	
Other Conditions Epilepsy	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Robertson M. D.
Address 2835 Gwynns Falls Pky Date signed 8/13/48

X

G65897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES J. FARRELL

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1898

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business

FATHER
12. Name James J. Farrell, Sr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name A. Forestall
15. Birthplace Baltimore

16 (a) Informant Miss G. Farrell
(b) Address 2110 Boone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address Greenmount Ave & 22nd.

AUG 16 1948
(Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/48 19 to 8/12/48 19, and that I last saw him alive on 8/12/48 19

Immediate cause of death: Coronary Thrombosis — Duration: sudden
Due to
Due to
Other Conditions Ac, Fibrous Pleurisy — 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] Date signed 8/13/48
Address 1901 Eutaw Place, City

VS 150

G65898

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65898 Registered No.

CERTIFICATE OF DEATH 186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose ave
(c) Hospital or institution: Ardleigh Nursing Home also Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anastasia Thomazos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eustratios

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kanicolas
13. Birthplace Greece

MOTHER
14. Maiden Name
15. Birthplace Greece

16 (a) Informant Stephen Hayes
(b) Address 1903 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16-48 (month) (day) (year)
(c) Cemetery or crematory Greek Com.
Location Windsor Mill Rd

18 (a) Funeral director Lambros Fun. Hom Inc
(b) Address 440 E North ave

19 (a) 8/16 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Aug 13 1948, and that I last saw her alive on Aug 13 1948.

Immediate cause of death Myocardial Insufficiency Edema of the lungs — Duration

Due to Arteriosclerotic Cardiac — 2 yrs

Due to Chronic

Other Conditions Fractured neck of femur — 2 wks
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20th
(a) Accident, suicide, or homicide Fracture Complicated
(b) Date of occurrence Aug 20 at 9P M
(c) Where did injury occur? 1903 W. Franklin St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fell while walking

23. Signature [illegible] M. D.
Address 342 W Lexington St Date signed 8/16/48

VS 11

G.F. Merrill MD

G65893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G65899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Presbury St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Presbury st.
(If rural give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3 (a) FULL NAME FRANCES E. FISHER nee RANDLE

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Raymond Fisher

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr): MAR. 27, 1888

8. AGE: Years: 60 | Months: 4 | Days: 18 | If less than one day: 19 hr. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Burper

11. Industry or business: Knitting

FATHER 12. Name: Joseph Randle

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden Name: Margaret Winters

MOTHER 15. Birthplace: Maryland

16 (a) Informant: Mrs. P. Raymond Transfelter

(b) Address: 5619 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~: Loudon Park

Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons

(b) Address: Death & Po. Ave.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) ~~marriage or burial~~ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948. to Aug. 15 1948. and that I last saw her alive on Aug. 15 1948.

Immediate cause of death: Carcinoma of liver

Duration: about 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 29, 1948

Major findings of operation: Carcinoma of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Geo J. Gover M.D. M. D.

Address: Mallow Hill Ave Baltimore Md Date signed 8/16/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G65900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G65900
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) ~~Hospital~~ or institution:
R. D. Wilson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County -
(c) City or ~~town~~ BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Bolton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDGAR TOMPKINS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: widowed

6 (b) Name of ~~husband~~ or wife: Mary L. Tompkins
NEE - McCORT

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1867

8. AGE: Years 81 | Months 4 | Days - | If less than one day: hr. min.

9. Birthplace: Clarkstown, N. Y.
(Town, county, and state)

10. Usual Occupation: Printer

11. Industry or business: Retired

FATHER
12. Name: Sidney B. TOMPKINS
13. Birthplace: New York

MOTHER
14. Maiden Name: MARY H. YOCUM
15. Birthplace: New York

16 (a) Informant: Mr. Raymond L. Tompkins
(b) Address: 5407 Falls Rd. Terrace

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof: 8/17/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Lorraine
Location:

18 (a) Funeral director: Wm J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1948, to Aug. 16 1948, and that I last saw him alive on Aug. 14 1948:

Immediate cause of death: Carcinoma of Lung — Duration: 6 mos.?

Due to:

Due to:

Other Conditions: Senility; Myocardial failure.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Robt. B. Wright M. D.
Address: Medical Arts Bldg. Date signed: 8/16/48

VS 159

G65901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 43B

G65901
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N Pennington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Pennington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Anne Floar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: ~~Female~~

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ~~Married~~ Widow

6 (b) Name of husband or wife: John J. Floar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/18/1870

8. AGE: Years 77 | Months 10 | Days 26 | If less than one day hr. min. 25

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business housework at home

FATHER
12. Name Joseph Cremer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Cath Drager
15 Birthplace Baltimore

16 (a) Informant Mr Truman Blair
(b) Address 812 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. Baker Sons
(b) Address 1318 Light St

19 (Date rec'd by registrar) AUG 16 1948 Huntington Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1948, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to Aug 13 1948, and that I last saw her alive on Aug 13 1948.

Immediate cause of death: cerebral thrombosis — Duration 4 days

Due to: cerebral arteriosclerosis — 3 years

Due to: generalized arteriosclerosis — 5 years

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur a. ome, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geny A Kemp M.D.
Address 3030 Edmondson Ave Date signed 8/14/48

VS 159

C65902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C65902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... 11-
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ... 3
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Orchard Street (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Eva Crofton

3 (b) If veteran, name war ...

3 (c) Social Security Account No. 421-07-9998

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife ...

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1898

8. AGE: Years 49 | Months 10 | Days 5 3 | If less than one day ... hr. ... min.

9. Birthplace Ashby, Alabama (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ...

FATHER
12. Name Winston Evans
13. Birthplace Alabama

MOTHER
14. Maiden Name Rachel Allen
15. Birthplace Alabama

16 (a) Informant Stanley Crofton
(b) Address 402 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)

(c) Cemetery or crematory ...
Location Lincolnton, Ala.

18 (a) Funeral director Charles P. Law
(b) Address 402 Pennington Ave., Md.

19 (a) AUG 16 1948 (Date received by local Registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1948 at 1:30A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur? ...
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...
(d) Means of injury ...

23. Signature ... M.D.
Medical Examiner.

Date signed 8 Aug 48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 437

Registered No. G65303

65903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE WILHELMINA CHARLOTTE CADDELL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas W. Caddell

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 2. 1871

8. AGE: Years 77 | Months 8 6 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Willner
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Barbara Wehr
15. Birthplace Germany

16 (a) Informant Mr. Irwin Caddell (Son)
(b) Address 307 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17. 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13. 1948 at 8.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Aug 13 1948 and that I last saw h[illegible] alive on Aug 13 1948

Immediate cause of death
Cerebral Hemorrhage
Due to Arteriosclerosis
Due to Cardiac Decompensation
Other Conditions

Duration 5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Eutaw Pl. Date signed 8/14/48

L. B. Stevens

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Mt. Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgiana Covell

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William D. Covell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1865

8. AGE: Years	Months	Days	If less than one day
82, 83	10	15th	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Thomas J. Ward
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Nicholson
15. Birthplace Md.

16 (a) Informant Carroll S. Covell
(b) Address 301 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Ave

18 (a) Funeral director Mrs. John H. Diehl Son
(b) Address 2311 Edmondson Ave

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to August 14 1948, and that I last saw h alive on August 14 1948.

	Duration
Immediate cause of death Myocardial degeneration + insufficiency	6 months
Antecedent causes Coronary Sclerosis	
Morbid conditions Post. hypertensive cardiovascular disease, Trophy and Congestive failure	2 years
Due to Generalized arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Trichel M. D.
Address 2901 Edmondson Ave Date signed Aug 15 19

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G65905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 121 ✓

Registered No. G65905

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)

(d) Street No. Riviera Beach (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Carrie Phelps

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 1, 1889

8. AGE: Years	Months	Days	If less than one day
63	10	13	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name August Weaver

13. Birthplace Baltimore

MOTHER 14. Maiden Name Caroline Zink

15. Birthplace Pa.

16 (a) Informant GEORGE C. PHELPS

(b) Address 200 E. DORIS AVE -25

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)

(c) Cemetery or crematory GLEN HAVEN

Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.

(b) Address 715 LIGHT ST - 30

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Nottingham, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1948, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/14 1948.

Immediate cause of death Paralytic ileus

Due to Ruptured Gangrenous appendicitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Adynamic ileus

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank A. Lavanty, M.D.

Address Lond. Ave. Hosp. Date signed 8/17/48

VS 1-50

C65906

ES-92463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

110 B

Registered No. C65906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Friendly Inn, Sharp St. (If rural give location)
207 E. Sharp St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1875?

8. AGE: Years	Months	Days	If less than one day
72?	7	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Records- Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Glen Rovell
Location Glen Burnie, Md.

18 (a) Funeral director Gilbert & Son
(b) Address 2117 E. Fort Ave.

19 AUG 16 1948 (Date rec'd by Registrar) (b) Evelyn Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 11 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 3-8 1945 to 8-15 1948, and that I last saw him alive on 8-15 1948

Immediate cause of death Congestive heart failure - Cerebral edema and Cerebral Thrombosis

Duration

Due to -

Due to -

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren E. Porter M.D.
Address Date signed 8/16/48

VS 150

63907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G65907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1955 Perlman Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1955 Perlman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Cahill
3 (b) If veteran, name war
3 (c) Social Security Account No. 211-07-2144

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 8th 1898

8. AGE: Years 49 | Months 8 | Days 6 | If less than one day hr. mi.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Cahill
13. Birthplace Md

MOTHER
14. Maiden Name Clara Mershman
15. Birthplace Md

16 (a) Informant Mrs. Cahill
(b) Address 1955 Perlman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17th 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park ave

19 AUG 16 1948 (Not to be filled in by Registrar) (b) Huntington Williamsport, Pa.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1948, to Aug 17 1948, and that I last saw h alive on Aug 13, 1948.

Immediate cause of death: Terminal pneumonia — Duration: 1 day

Due to Carcinoma of Kidney (left) — ?
Secondaries everywhere

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Early July 1948

Major findings of operation: Carcinoma of Left Kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfet M. D.
Address 714 E. Preston St Date signed Aug 19

Samuel Silverfet

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

665908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 665908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. Balto. Gen'l. 15
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ruth Uttermahlen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18 - 1884

8. AGE: Years 54 | Months 6 | Days 28 | If less than one day hr. 14 min. 44

9. Birthplace Carroll County Md
(Town, county and state)

10. Usual Occupation Sales Lady

11. Industry or business Operator

FATHER
12. Name Henry Uttermahlen
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Humbert
15. Birthplace Maryland

16 (a) Informant Mrs. C. L. Wolfe
(b) Address Union Bridge, Md R.D.

17 (a) Burial (b) Date thereof 8/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baust Cemetery
Location Taneytown Road

18 (a) Funeral director H. H. Hartzler & Sons
(b) Address Union Bridge & Uniontown, Md

AUG 16 1948
(Date received by registrar)

(c) Uniontown, Md
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 8:51 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull
Intracranial Hemorrhage

Due to Intracranial

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 178
(a) Date of injury August 16/48 8:35 A. M. P.M.
(b) Where did injury occur? Clifton & Allendale
(c) Did injury occur at home, on farm, industrial place, in public place? Street intersection (While at work?) No
(d) Means of injury: Struck by streetcar

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-16-48

VS 181

X

G65909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Saint Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Suddie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1878

8. AGE: Years 70 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Marsh Wilson

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Ann Scherrer

15. Birthplace N. C.

16 (a) Informant Hunter Barnard

(b) Address 1419 Federal St

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Aug 16/48 (month) (day) (year)

(c) Cemetery or crematory

Location Camden Cy. N. C.

18 (a) Funeral director Mrs Rose Elliott Day

(b) Address 1129 N. Carrollton St

19 (a) (Signature) (b) Registrar

(Registered by registrar's office)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 5:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Ernest L. Rose M.D.
Medical Examiner.

Date signed Aug. 14/48

LVS 15)

G665910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G665910 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Parkman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Parkman Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Popp

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Barbara Popp
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) February 24, 1870

8. AGE: Years 78 | Months 5 | Days 22 | If less than one day: 21 hr. ——— min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cooper
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Popp
(b) Address 1301 Parkman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George [illegible]
(b) Address 2101 Frederick Ave.

19 (a) 8-16-1948 (b) [illegible] (Date received by Registrar) Washington Ndlandsen

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948 at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27/47 19 to 8/15/48 19
and that I last saw h.im alive on 8/2/48 19

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clinton Tousley M.D.
M. D.
Address 2411 Washington Blvd. Date signed 8/16/48
2411 WASHINGTON BLVD.

VS 150

Correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

5911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83c

Registered No. GG5911

correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Brooks Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mon., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Brooks Lane
(If rural give location)
(e) Citizen of foreign country? Belt St (Yes or No)
If yes, name country

3 (a) FULL NAME Lucinda V. Magers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James T. Magers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1862

8. AGE: Years	Months	Days	If less than one day: hr.	min.
86	4	11		

9. Birthplace Mt. Airy Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Thomas Harris
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Chas. E. Magers
(b) Address 1819 Belt St.

17 (a) Burial (b) Date thereof 8/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Pinehurst Grove United Brethren
Location Raywille Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

AUG 17 1948
(Date rec'd by registrar)

(b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1948, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/1948, to 8/13/1948, and that I last saw h[illegible] alive on 8/13/1948.

Immediate cause of death Encephalomalacia

Due to Arteriosclerosis

Due to

Other Conditions Bilateral cataract
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration: 5 mths

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Weidenger M. D.
Address 912 Brooks Lane Date signed 8/17/48

V S 150

5912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. C65912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 North Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada AGUINAGA (ANNA AGUINAGA)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Aguinaga

6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): August 25, 1904

8. AGE: Years: 43 | Months: 11 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Restaurant

11. Industry or business: 707 S. Broadway

FATHER
12. Name: ? Goldberg
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Mr. Edward Aguianga
(b) Address: 1813 N. Broadway

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof:** 8/18/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 AUG 17 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1948, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture 9-10 Dorsal Vertebra

Due to

Other Conditions 2nd + 3rd Degree Burns 1/5 Body Surface
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: August 15, 1948 Approx. 4:30 A.M.
(b) Where did injury occur? 1813 N. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Jumped from 3rd fl. window because of a fire at the house

23. Signature [signature] M.D. Medical Examiner
Date signed: 8-16-48

G65913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G65913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 Gorsuch Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS HENRY HARRINGTON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Daisy Bedsworth
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 18. 1869

8. AGE: Years	Months	Days	If less than one day
78	11	28 29	hr. min.

9. Birthplace Bivalve - Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Beecham Harrington
13. Birthplace Bivalve Md.

MOTHER
14. Maiden Name Deal ?
15. Birthplace Maryland

16 (a) Informant Harlan S. Harrington
(b) Address 1356 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. 1948 (month) (day) (year)
(c) Cemetery or crematory Bivalve Cemetery
Location Bivalve Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

AUG 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16. 1948 at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1948 to Aug 16 1948. and that I last saw him alive on Aug 15 1948.

Immediate cause of death

Duration

Myocarditis 1 yr.

Due to

Due to

Other Conditions Cerebral arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Janet Fosbrink M. D.
Address 182 N. Mulberry St. Date signed 8/16/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65914 Aug 312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County
(c) City or town Haddonfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter K. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 12-11-1900

8. AGE: Years: 47 Months: 8 Days: 6 If less than one day: hr. min.

9. Birthplace: Philadelphia Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Harris Moore

FATHER 13. Birthplace: N J

MOTHER 14. Maiden Name: Elizabeth Ware

MOTHER 15 Birthplace: Ohio

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof 8/20 (month) (day) (year)

(c) Cemetery or crematory Harleigh Cem

Location Camden N J

18 (a) Funeral director Charles P Tossell

(b) Address 2407 Kalmia Rd Balto

19 AUG 17 1948 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 3:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8-17 1948, and that I last saw him alive on 8-17 1948.

Immediate cause of death Myocardial infarction, acute, posterior, c pulmonary edema, acute

Due to Arteriosclerotic Cardiovascular Disease, c coronary artery insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E Starrer M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-17-48

Norman E. Starrer

5915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 065915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 576 N Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 576 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis J. Horan

3 (b) If veteran, name war None

3 (c) Social Security Account No. 077-05-5701

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret (Edna C.) Horan

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Feb 15 1888

8. AGE: Years 60 (Est) | Months 6 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace (City or town, county, and state) Marlborough N.Y.

10. Usual Occupation Salesman

11. Industry or business Shoe

FATHER 12. Name John Horan

13. Birthplace

MOTHER 14. Maiden Name Catherine McCourt

15. Birthplace Pickell

16 (a) Informant Edna C. Horan

(b) Address 576 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1948 (month) (day) (year)

(c) Cemetery or crematory Location Philadelphia Penna

18 (a) Funeral director Roff C. & M. Walker

(b) Address Pratt & Stricker Sts

19 (a) AUG 17 1948 (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Aug. 16 1948, and that I last saw h/ alive on 8/12 1948.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Chas. Langhlin M. D.

Address 400 N. Payson St Date signed 8/16/48

D. C. Wa. Langhlin X

65916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G65916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B. Hurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1903

8. AGE: Years 44 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Hurwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Chesler
15. Birthplace Russia

16 (a) Informant James J. Hurwitz
(b) Address 2336 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

AUG 17 1948 (Date rec'd by registrar) Washington Millican, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1948, at 1:10A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Louis B. Hurwitz M.D. Medical Examiner
Date signed 8-16-48

VS 151

917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 66 917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 E Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 3402 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E Lambert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John M Lambert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1865

8. AGE: Years 79 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name August Hagemeier
13. Birthplace Ger

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Lena Hamm
(b) Address 524 N Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Oakmont St

19 AUG 17 1948 (b) [illegible]
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1948, at 2 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946, to August 15 1948.
and that I last saw h alive on 8/15 1948.

Immediate cause of death Cardiac dysphagia — Duration

Due to

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3402 E Balto Date signed 8/16/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

83a

G65918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65918
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(c) State Md. (b) County Balto.
(c) City or town Deer Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lutherville, Post Office
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME H. Marshall Fritz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Elizabeth Musgrave

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) don't know

8. AGE: Years 89 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Liberty, Frederick, Md
(Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business

FATHER
12. Name Mathias Fritz
13. Birthplace Dont Know

MOTHER
14. Maiden Name Julia Zepp
15. Birthplace dont Know

16 (a) Informant Earl Bray
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 '48 (month) (day) (year)
(c) Cemetery or crematory Reisterstown M.E.
Location Reisterstown, Md

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, Md

19 (a) Date received AUG 17 1948 Registrar [illegible] Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 8-15-1948, and that I last saw h[illegible] alive on Aug. 10 1948.

Immediate cause of death Myocarditis
Chronic
Due to Hypertension
Due to Arteriosclerosis
Other Conditions

Duration 2yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Reisterstown, Md. Date signed 8-16-48

VS 3

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

5319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 665919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Belvedere Home for Aged 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Isaac Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Widower

6 (b) Name of husband or wife Sara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Nathan Warshaw
(b) Address 2248 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pikesville Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Pl

19 (a) AUG 17 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 - 1948, at 11 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to August 16 1948, and that I last saw him alive on 8-16 - 1948

Immediate cause of death: Coronary thrombosis — Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.
Address Evergreen Avenue Date signed 8-16-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. C65920

35920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & St
(c) Hospital or institution: Levan 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Norfolk Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Sindler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name L. M. Zaret
13. Birthplace Poland

MOTHER: 14. Maiden Name Rebecca Lotte
15. Birthplace Poland

16 (a) Informant Barney Sindler
(b) Address 3902 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 760 Eutaw Place

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 9.08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948, to 8-15 1948, and that I last saw her alive on 8-15 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions Hypertension kidneys and Gall stones (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 8-15-48

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly

5921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. 085921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 S. CONKLING ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 S. CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD L. GOCHENOUR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-39.

8. AGE: Years	Months	Days	If less than one day
9	0	27	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CHILD.
11. Industry or business

FATHER
12. Name HOWARD F. GOCHENOUR
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name VIRGINIA I. SCHAFER
15. Birthplace BALTO., MD.

16 (a) Informant HOWARD F. GOCHENOUR
(b) Address 1002 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7225 EASTERN AVE.

18 (a) Funeral director Charles S. Sailer
(b) Address 901 S. CONKLING ST.

AUG 19 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 15 1948 at 8.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1941 to AUG. 15 1948, and that I last saw h/m alive on AUG. 14 1948.

Immediate cause of death CEREBRAL HEMORRHAGES — Duration 4 HRS.
Due to EPILEPSY — 9 YRS.
Due to CONGENITAL BRAIN INJURIES — 9 YRS.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 124 S. HIGHLAND AVE. Date signed AUG. 15 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

65922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 65922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Elsinor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Napoleon B. Warner

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	male	white	single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/2/1869

8. AGE: Years	Months	Days	If less than one day
79	5	14	hr. min.

9. Birthplace Loudon Co. Va. (Town, county, and state)
10. Usual Occupation Retired-
11. Industry or business Farming

FATHER
12. Name Gabrial V. Warner
13. Birthplace Loudon Co. Va.

MOTHER
14. Maiden Name Elizabeth Stacks
15 Birthplace Loudon Co. Va.

16 (a) Informant Mrs. Eliz. Nicholson
(b) Address 2213 Elsinor Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery ~~Woodlawn~~ Lakeview Cem.
Location Hamilton, Va.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 17 1948 (Date rec'd by registrar) Harrington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1948 to 8/16 1948. and that I last saw him alive on 8/16 1948.

Immediate cause of death: cardiac failure — Duration
Due to chronic nephritis
Due to uremia
Other Conditions arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which)
(e) Means of injury

23. Signature W Schuchler M.D.
Address Bon Secours Hosp Date signed 8/16/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 665923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Baltimore St.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Virginia Esterley

5 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-7451

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Richard E. Esterly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1879

8. AGE: Years 49 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William G. Haggett
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Clarabelle E. Long
15. Birthplace Jefferson, Md.

16 (a) Informant Esther R. Haggett
(b) Address 2304 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Frederick R. Cole
(b) Address 1210 W. Lanvale St.

AUG 17 1948 (Date Accepted by Registrar) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1948 at 9:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 7 1948, to Aug. 14 1948, and that I last saw h[illegible] alive on Aug. 14 1948.

Immediate cause of death
Chronic Lymphoid Leukemia — Duration 5 years.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein, M.D.
Address West Baltimore Hosp. Date signed 8/14/48

VS 190

X

665924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 665924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Durham St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Pauline Smetana.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank Anthony
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1904

8. AGE: Years	Months	Days	If less than one day
43	10	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob F. Ihle
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Kame
15. Birthplace Germany

16 (a) Informant Frank Smetana
(b) Address 1617 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1948 (month) (day) (year)
(c) Cemetery Baltimore Lawn
Location E. North Ave. Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

19 (Date received by registrar) Lexington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-15 1948, and that I last saw her alive on 8-15 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic Heart Disease	
Due to Rheumatic Fever	35 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Joseph Krajci M. D.
Address 1400 N. Caroline St Date signed 8-16-48

G65925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

Registered No. G65925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Madeira, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Elmer Leonard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Louise Leonard
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 16 - 1900

8. AGE: Years	Months	Days	If less than one day
48	2-1	0	29 hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Rochester

FATHER 12. Name Winfield S. Leonard
13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth
15. Birthplace ?

16 (a) Informant Winfield S Leonard
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1948 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Butler Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) Date received by registrar Aug 17 1948 (b) Registrar Huntington Williamson, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 15 - 1948 at 12 5-5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1948 to 8-15- 1948, and that I last saw him alive on 8-15- 1948.

Immediate cause of death: Respiratory Failure — Duration: 0
Due to: Medullary herniation. — 0
Due to: Cerebro vascular accident — 1½ d
Other Conditions: Coarctation of Aorta — Life
(Include pregnancy within 3 months of death)

PHYSICIAN: Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Aug 15

065926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. 065926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd & CALVERT STREETS
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 ROLAND AVENUE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

2 (a) FULL NAME MRS. HERMAN L. PIEL (DORA M.)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: HERMAN L. PIEL
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) APRIL 24 1870

8. AGE: Years 78 | Months 3 | Days 24 | If less than one day: ____ hr. ____ min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation: NONE

11. Industry or business

FATHER
12. Name JOHN HENRY STUTT
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARY BUTCHER
15. Birthplace GERMANY

16 (a) Informant Herman D. Piel
(b) Address 208 Ridgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1960 Eastern Place, Balto 18

19 (a) AUG 17 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-48 1948, at 12 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-48 1948, to 8-15-48 1948 and that I last saw HER alive on 8-15-48 1948.

Immediate cause of death	Duration
GENERALIZED PERITONITIS	
Due to PERFORATION OF RECTUM	
Due to CARCINOMA OF RECTUM	
Other Conditions CARDIO VASCULAR HEART DISEASE (Include pregnancy within 3 months of death)	

Date of operation 8-14-48

Major findings of operation: GEN'L PERITONITIS PELVIC ABSCESS, PERFORATION OF RECTUM

or Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Watts, Jr. M. D.
Address Union Memorial Hospital Date signed Aug 15, 1948

VS 150

G65927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

Registered No. G65927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Baker St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Little

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Ella Rose Little
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 26, 1861

8. AGE: Years 87 | Months 0 | Days 21 | If less than one day: ____ hr. ____ min.

9. Birthplace: York, Penn. (Town, county, and state)
10. Usual Occupation: Funeral Director
11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden Name: Margaret E. ?
15. Birthplace: Westmoreland CO. Va.

16 (a) Informant: George A. Little
(b) Address: 2923 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 AUG 17 1948 (Date received by Registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 8.1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1946 to Aug 16 1948 and that I last saw him alive on Aug 16 1948

Immediate cause of death: Chr. Myocarditis — Duration: 1940

Due to: C.h. Interstitial nephritis — Duration: 1940

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Paul E. Brown M.D.
Address 1663 W. North Ave. Date signed 8-7-48

VS 150

X

G65928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G65928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold F. BABCOCK

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 012-07-9848

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1891

8. AGE: Years	Months	Days	If less than one day
57	2	15	hr. min.

9. Birthplace Westerly, R.I.
(Town, county, and state)
10. Usual Occupation Claim Examiner
11. Industry or business Insurance

FATHER
12. Name Frederick Palmer Babcock
13. Birthplace Westerly R.I.

MOTHER
14. Maiden Name Ann Eliz. Chapman
15. Birthplace Westerly R.I.

16 (a) Informant: Avery Funeral Home
(b) Address Westerly R.I.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at M

21. I certify that I took charge of the remains described above, held an Inspection and Exam. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchial asthma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 8/16/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G65929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

Registered No. G65929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home 3906 Gelston Drive
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Gelston Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David A. Manger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/35

8. AGE: Years	Months	Days	If less than one day
14	8	24	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvan A. Manger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Thelma Hoffman
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 3906 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 18 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown Md.

18 (a) Funeral director Harry W. Witte
(b) Address 4101 Edmondson Ave

19 (a) (Signature of registrar) (b) Registrar

AUG 17 1948

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/1948 at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1948 to 8/15 1948, and that I last saw him alive on 8/15 1948

Immediate cause of death Poliomyelitis — Duration 5 days of illness

Due to Bulbar Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene D. Gladstein M. D.
Address Sydenham Hospital Date signed 8/15

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

G65930 A1903 ✓ G65930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N. Carrollton Ave
(c) Hospital or institution: 16-1
(d) Length of stay in hospitl or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age/ years

7. Birth date of deceased (mo., day, yr.) August 2, 1900,

8. AGE: Years 47 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace Hartford County, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas H. Amos.

13. Birthplace Hartford, County Md.

MOTHER 14. Maiden Name Mary F. Jenkins,

15. Birthplace Hartford County, Md.

16 (a) Informant Miss Effie Amos

(b) Address 802 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1948 (month) (day) (year)

(c) Cemetery or crematory Fair View

Location Hartford County, Md.

18 (a) Funeral director Mrs. Katie R. Wilkins

(b) Address 322 N. Schroeder St. Lexington Park, Md.

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home or farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil H. Beyer M.D. Medical Examiner.

Date signed 15 Aug 48

VS 151

G65931 ✓ G65931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 754 Vine St.,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ellis Dent

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Ellis Dent
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1887.

8. AGE: Years 60 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James E. Dent
13. Birthplace Md.

MOTHER
14. Maiden Name Patricia Blair
15. Birthplace Md.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1948. (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 19 48 to Aug 14 19 48, and that I last saw him alive on Aug 14 19 48.

Immediate cause of death: Cirrhosis of liver with ascites, esophageal varices, gynecomastia
Due to: Intestinal obstruction, (ileum), due to adhesions
Other Conditions: Inguinal hernia, left
Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Duration
15 yrs

Date of operation none
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew J. McQueeney M. D.
Address Marine Hospital Date signed 8/15/48

VS 150

G65932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

V G65932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave 12-
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 N Howard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pink Harris.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4 1904

8. AGE: Years 43 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Kentucky.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Harris.
13. Birthplace Kentucky

MOTHER
14. Maiden Name Anna Waters
15. Birthplace Ohio

16 (a) Informant Elliott Adkins.
(b) Address 2130 N. Howard St.

17 (a) Burial (Buried, cremation, or removal) (b) Date thereof August 19, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/13 1948.

Immediate cause of death Cardio respiratory failure — Duration ? 10 years

Due to Hypertension Cardio-vascular disease — Duration 10 yrs

Due to Chronic nephritis — Duration 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Hagen, M.D.
Address Maryland General Hospital Date signed 8/14/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G65933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G65933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1874

8. AGE: Years 74 | Months 70 | Days aug 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Joseph Salter
13. Birthplace Md.

MOTHER — 14. Maiden Name Elizabeth Price
15. Birthplace Md.

16 (a) Informant Mrs. Mary Savage
(b) Address 633 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 17 1948 (Date received by registrar) (b) Frances A. Hemsley Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH August 16, 1948 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1948 to Aug. 16 1948, and that I last saw her alive on Aug. 15 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 9 days

Due to: Hypertensive Cardio-Vas. Dis.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald M. D.

Address 844 N. Carey St. Balto. Date signed 8/17/48

VS 150

Please write plainly, with pen or indelible pencil. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65934 231766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G65934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 E. Eager 21 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Clapp. (Lula E. Clapp).

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-14-4767

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm. E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-99

8. AGE: Years 48 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home (Nature of work)

FATHER 12. Name Milton Morrison

13. Birthplace N. C.

MOTHER 14. Maiden Name Millie Leach

15. Birthplace N. C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location

18 (a) Funeral director Robert L. Conner

(b) Address 6716 W. Cardina St.

19 AUG 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948 at 11:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug. 16 1948 and that I last saw her alive on Aug 16 1948

Immediate cause of death: Probable cerebral thrombosis — Duration: hrs.

Due to: Hypertensive cardio-vascular dis. — years.

Due to:

Other Conditions: Gen. Arteriosclerosis — years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Arteriosclerosis + edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony V. Izzo. M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-16-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G65935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Roland avenue
(c) Hospital or institution: Kirkleigh Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Kirkleigh Villa (If rural give location)
+ 301 Roland Ave.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN M. JOHNSTON

3 (b) If veteran, name war ----- | 3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 13, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden Name Caroline Costello
15. Birthplace Baltimore, Md.

16 (a) Informant Rev. Sr. M. Germaine
(b) Address 4301 Roland ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 18-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas. G. Evans' Sons Inc
(b) Address 118 W. Mt. Royal Ave.

19 (a) AUG 17 [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1948, to Aug. 15 1948, and that I last saw her alive on Aug. 15 1948.

Immediate cause of death Hypertensive cardiovascular disease.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Deaths

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. Johnson M. D.
Address 701 N. Kenwood Ave. Date signed 9-16-48

VS 150

G65936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G65936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 York Court (18) (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E Vaughan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Eugene P. Vaughan
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr) JAN 29-1861

8. AGE: Years 87 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name MAHER
13. Birthplace Ireland

MOTHER — 14. Maiden Name CATHERINE WARD
15. Birthplace IRELAND

16 (a) Informant MRS. WILLIAM I WALSH
(b) Address 12 York Court

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 19-1948 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) AUG 17 1948 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 11:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1948 to Aug 16, 1948 and that I last saw her alive on 8-16-1948

	Duration
Immediate cause of death Acute Cardiac Failure	
Due to Old age, cachexia	
Due to Phlebothrombosis	
Other Conditions Fract. Ischium	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-9-48 at ? M
(c) Where did injury occur? 12 York Co. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify) While at work? no
(e) Means of injury slipped + fell to floor

23. Signature C. D. Thomas, M. D.
Address Mercy Hosp. Date signed 8-16-48

Howard J. Timmis, M.D.
1009

BC-48-16905

G65937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G65937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Berry St Balt (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/48

8. AGE: Years	Months	Days	If less than one day: hr.	min.
0	0	2		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Charles R. Jenkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Jane Judsel
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director George B. Fuhrman
(b) Address Baltimore Fayette St.

19 (a) AUG 17 1948 (Date received by registrar) Huntington Williams Md. (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/48 19 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1948 to 8/15 1948 and that I last saw him alive on 8/15 19 48

Immediate cause of death Resp. failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)
(e) Means of injury

23. Signature Joseph L. Gourley, M.D.
Address Mercy Hosp. Date signed 8/15/48

VS 150

G65938 ✓ G65938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 101

2C- 6904-36

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Monastary Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Katherine~~ KATHLEEN Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1947

8. AGE: Years	Months	Days	If less than one day
	10	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John A. Rose
13. Birthplace Philadelphia

MOTHER 14. Maiden Name Teresa Wilson
15. Birthplace Baltimore

16 (a) Informan: Mrs. John A. Rose
(b) Address 107 N. Monastary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Fuhrley
(b) Address Shelton Bldg. Fayette St.

19 (a) AUG 17 1948 (Date received by Registrar) (b) Burial permit issued

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948, at 9.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
Due to Acute Dilatation of Heart
Other Conditions Mesenteric Adenitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at (Work)
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed August 16, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

95c

665939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ 665939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eastern Ave 2
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Md. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charlotte Belle Fort

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife (Single) —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 28 1870

8. AGE: Years 78 | Months 0 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Music Teacher

11. Industry or business Music

FATHER 12. Name Leander Fort
13. Birthplace Balto Md

MOTHER 14. Maiden Name Ella Curtis
15. Birthplace Balto Md

16 (a) Informant Mrs W. L. Blanck (niece)
(b) Address 2330 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Greenmt
Location Balto. Md.

18 (a) Funeral director Sullivan Mortuary
(b) Address 108 W Monument St

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions Fracture of right hip

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 7-24-48 at ? M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slipped and fell to floor

23. Signature [signature] M.D. Medical Examiner.
Date signed 8-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town ? (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Hammonds Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosalie SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years: 24 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day)
(c) Cemetery or crematory
Location University Medical School

AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 AUG 17 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia of both lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/9/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G65941

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Lemmon St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie B. Applin

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1889

8. AGE: Years	Months	Days	If less than one day
58	9	22	hr. min.

9. Birthplace Harrisburg Va.
(Town, county, and state)

10. Usual Occupation Household work
11. Industry or business at Home

FATHER
12. Name John Goodman
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Flemming
15. Birthplace Va.

16 (a) Informant Mr. Edward Applin
(b) Address 939 Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem Pk
Location Washington Blvd

18 (a) Funeral director John T. Cowan & Son
(b) Address 90-03 Hollins St

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1948, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3- 1948 to Aug 15- 1948, and that I last saw her alive on Aug 5 1948.

Immediate cause of death Acute Coronary Occlusion — Duration 4 hours
Due to coronary artery disease — 1 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Rawlin
Address 206 S. Gilmor St. Date signed 8-16-48 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G65942

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 McCulloh St
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	Widowed

6 (b) Name of husband or wife Charlotte Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	4	hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name James W. Lee
13. Birthplace md

MOTHER
14. Maiden Name Lucy Woodland
15. Birthplace md

16 (a) Informant Lucy Lenkins
(b) Address 2315 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Lange & Nelson
(b) Address 1203 Pressstman St

19 AUG 18 1948 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Aug 14 1948, and that I last saw him alive on Aug 13 1948.

Immediate cause of death carcinoma of the prostate — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Puttermann
Address 2324 Reisterstown Rd Date signed M. 8 D. 17/48

VS 150

5943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kuhn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1875

8. AGE: Years 73 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Robert R. Kuhn
13. Birthplace Germany

MOTHER 14. Maiden Name Olivia Ballinger
15. Birthplace Washington D.C.

16 (a) Informant Frank Kuhn
(b) Address 2741 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Eugene F. Hoffman
(b) Address 1637 Broadway (Huntington, Indiana)

19 AUG 18 1948 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1948 at 7:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/16 1948 to 8/16 1948 and that I last saw h alive on 8/16 1948.

Immediate cause of death Cardiac failure - Coronary Sclerosis — Duration

Due to Arteriosclerotic Heart Dis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Hunter M.D.
Address Church Home Date signed 8/16/48

VS :53

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65944

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65944
Registered No.

CERTIFICATE OF DEATH

17 DC

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen Hosp 274
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Leo McQuaid Jr

3 (b) If veteran, name war: 2 nd

3 (c) Social Security Account No. 217-20-3758

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 19-1926

8. AGE: Years: 22 | Months: 5 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Vincent Leo McQuaid Sr
13. Birthplace: Balto

MOTHER
14. Maiden Name: Mildred Ellicott
15. Birthplace: Balto

16 (a) Informant: Mr Vincent L. McQuaid Sr
(b) Address: 3803 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 19-48 (month, day, year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: J. J. Henderson
(b) Address: 3009 Pennsylvania ave

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1948 at 5 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Chest
Rupture of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 15 Aug at 4:15 A.M.
(b) Where did injury occur? Ft Smallwood Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger Auto

23. Signature: Emil K. Rey M.D.
Medical Examiner
Date signed 15 Aug 48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

065915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 065915

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Clifmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4244

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
M	W	

6 (b) Name of husband or wife Stella Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
55	7	25	hr. min.

9. Birthplace Newport (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business

FATHER
12. Name Leon Kwaczuski
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15 Birthplace Germany

16 (a) Informant Estella Smith
(b) Address 3126 Clifmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. Hinz & Son
(b) Address 3001 Kentucky Ave

AUG 18 1948 (Date rec'd by Registrar) Washington Hill Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-15 1948 and that I last saw him alive on 8-15 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Wm. Powell, Jr. M. D.
Address Mercy Hosp. Date signed 8-15-48

65946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ G65946 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 N. Pulaski St.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 N. Pulaske St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN MITTNACHT

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~xxxxx~~ Harry Mittnacht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1907

8. AGE: Years 41 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Calvin Oler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Kuhlmer
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Virginia Sebold
(b) Address 622 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore National
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 18 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1948 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Aug 15 1948
and that I last saw her alive on Aug 15 1948.

Immediate cause of death Cerebral hemorrhage due to Hypertension

Duration 1 mo.

Due to

Due to

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Mittnacht

Address 1921 Whitelock Date signed 8/17/48 M.D.

Vs 150

93a

G65947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 ✓ Registered No. G65947

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Wilkens Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie May Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Peter J. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 16, 1872

8. AGE: Years 75 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15 Birthplace unknown

16 (a) Informant EARL H. MILLER
(b) Address 1819 WILKENS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto-City

18 (a) Funeral director Mrs. John W. Feikel & Son
(b) Address 5311 Edmondson Ave

AUG 18 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 11.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1945 to Aug. 16 1948, and that I last saw her alive on Aug. 16, 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Carcinoma of the vulva

Due to

Other Conditions Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gaspard Kupp M. D.

Address 3030 Edmondson Ave. Date signed 8/17/48

X

G665948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G665948 Registered No. 1382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Shaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Shaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvester Lewis

3 (b) If veteran, name war 0 | 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lucy Lewis

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr min

9. Birthplace Petersburg Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Sylvester Lewis
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lucy Lewis
(b) Address 613 Shaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. & C., Md

18 (a) Funeral director Isaiah L Lewis
(b) Address 108 W Montgomery St

AUG 18 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1948 to 8-13 1948, and that I last saw him alive on 8-13 1948.

Immediate cause of death T.B. G.I. + Chronic Endocarditis — Duration

Due to ✓

Due to ✓

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C Capers M. D.
Address 1016 E. Shaw St Date signed 8-17-48

VS 150

65949 GM. 121972

BALTIMORE CITY HEALTH DEPARTMENT AUG 18 1948 Registered No. 65949

CERTIFICATE OF DEATH 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Washington ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis William Ruth

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 215-05-7559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mary A. Ruth
6 (c) If alive, give age yeans

7. Birth date of deceased (mo., day, yr.) Sept. 17 1876

8. AGE: Years	Months	Days	If less than one day
71	10	29	hr. min.

9. Birthplace MD. (Balto) (Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name John Ruth
13. Birthplace MD.

MOTHER
14. Maiden Name Margaret Richter
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto, Md.

18 (a) Funeral director Chilton Henry Sons
(b) Address 2024 Orleans St.

19 AUG 18 1948 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 16- 1948, at 6.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 9- 1948 to 8- 16- 1948, and that I last saw him alive on 8-16- 1948.

Immediate cause of death: Pulmonary tuberculosis — Duration: years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Cantor, M.D.
Address Baltimore City Hospitals Date signed 8/17/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66595O

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 66595O

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 241 S. Calhoun St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Lloyd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Albert Lloyd
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 2, 1897

8. AGE: Years	Months	Days	If less than one day
51	1	14	hr. min.

9. Birthplace Shippingsburg, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Charles Suter
13. Birthplace Shippingsburg, Md.

MOTHER
14. Maiden Name Sarah Unknown
15. Birthplace Shippingsburg, Md.

16 (a) Informant Albert Lloyd
(b) Address 241 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1897 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Radusch & Cole
(b) Address 1202 W. Lombard St.

AUG 18 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 1948 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Aug 16 1948, and that I last saw h[illegible] alive on Aug 16 1948.

	Duration
Immediate cause of death Acute myocardial failure	
Due to Arterio-sclerosis of Cerebr	2½ yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Donaldson M. D.
Address 4201 Wilkens Ave Date signed 8/17/48

V S 150

G65951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G65951 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Cornington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Cornington St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John F Espey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Emma M Espey
6 (c) If alive, give years

7. Birth date of deceased (mo., day, yr.) Mar 16 – 1867

8. AGE: Years	Months	Days	If less than one day
81	5	1	hr. min.

9. Birthplace Waterloo PA County (City, county, and state)
10. Usual Occupation Retired
11. Industry or business B & O

PARENTS
12. Name Joseph Espey
13. Birthplace Maryland
14. Maiden Name Elizabeth Espey
15. Birthplace Maryland

16 (a) Informant Emma M. Espey
(b) Address 1537 Cornington St
17 (a) [illegible] (b) Date thereof Aug 20-48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location
18 (a) Funeral director Chas L Fowell
(b) Address 3427 Eastern Ave
1948 AUG 18 1948 (b) [illegible]
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 1:30 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Aug 17 1948. and that I last saw h[illegible] alive on Aug 10 1948.

Immediate cause of death Respiratory failure — Duration
Due to Coronary occlusion
Due to Arteriosclerotic cardio-vascular renal disease
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Shorofsky M. D.
Address 6011 N. Monroe St Date signed 8/17/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Johnson Rich

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1883

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	5	5		

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Gaines
13. Birthplace Va.

MOTHER
14. Maiden Name Lucretia ?
15. Birthplace St Michaels Md

16 (a) Informant Hannah Gaines
(b) Address 1003 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrd Robt A. Elliott & Son
(b) Address 1129 W. Baltimore St

19 AUG 18 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1948 to Aug 15, 1948 and that I last saw him alive on 19

Immediate cause of death	Duration
Congestive Hrt. Failure	3 wks
Due to Hypertension	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 8-17-48

VS 190

G65953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65953 Registered No. 5855

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Bruce St
(c) Hospital or institution:

16 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Ingram

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife John Ingram.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day hr.	min.
66				

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Jessie Waters
FATHER 13. Birthplace Md

MOTHER 14. Maiden Name
MOTHER 15. Birthplace —

16 (a) Informant Samuel Waters
(b) Address 708 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Pennsylvania Ave

19 AUG 19 1948 (Date received by Registrar) (b) Registrar's No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1948, at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/14 1948.

Immediate cause of death Carcinoma of rectum

Due to Hypertension

Due to

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson A. Gullen/Blankenship M.D.
Address 601 N. Carlton Date signed 8/19/48

VS 150

939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66954

65954 - 104215

186a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Loraley, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. No Street Number (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hyde O'Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 8, 1881

8. AGE: Years 67 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Timothy J. O'Conner

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Gilbert

MOTHER 15. Birthplace Md.

16 (a) Informant Bs Co Hs Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)

(c) Cemetery or crematory Mayr Cathedral

Location Old Frederick Rd

18 (a) Funeral director John C Moran

(b) Address 3000 Walbrook Ave

AUG 18 1948 (Date Received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948, at 1.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1948 to Aug. 15 1948, and that I last saw him alive on Aug. 15 1948.

Immediate cause of death Acute pulmonary edema

Due to Acute cardiac failure

Due to

Other Conditions Luetic amyotrophic (Charcot-Marie-Tooth's) fract. R. hip

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Above (brain not yet received)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident 6-12

(b) Date of occurrence 8-8-48 at M

(c) Where did injury occur? Baltimore (City or town) Md (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Balto. City Hosp (Specify type of place) while at work? Yes

(e) Means of injury fell out of bed at hosp.

23. Signature [illegible] M.D.

Address Balto City Hosp Date signed 8-15-48

To be approved by Medical Examiner

VS 15)

G65955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G65955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Burgundy (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Patrick Farren

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: Ruth Farren

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Feb 21, 1902

8. AGE: Years 46 | Months 5 | Days 16/23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Patrick Farren
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Bortman
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Fisk & B. M. Walters
(b) Address 1501 Stricker St.

AUG 18 1948 (Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1948 to 8-16 1948, and that I last saw him alive on 8-16 1948.

	Duration
Immediate cause of death: Hemorrhage from esophageal varices	
Due to: Cirrhosis of Liver	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp. Date signed 8-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

065956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G65956

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Andrew Knudsen (RICHARD ANDREW KNUDSEN)

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 705-05-0070

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie Elizabeth Knudsen
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) 10/17/96

8. AGE: Years	Months	Days	If less than one day hr.	min.
51	10	29		

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Civil Engineer
11. Industry or business B. & O. R.R. Engineering Dept.

FATHER
12. Name Andrew Knudsen
13. Birthplace Norway

MOTHER
14. Maiden Name Not Known
15. Birthplace GERMANY

16 (a) Informant Mrs. Marie Knudsen
(b) Address 2113 Sinclair Lane - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. '48 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore Maryland.

18 (a) Funeral director HENRY SNYDER & SONS, INC.
(b) Address North Ave & Broadway. Baltimore 18

19 (a) AUG 18 1948 (Registrar's number) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948 to Aug. 16 1948 and that I last saw him alive on Aug. 16 1948

Immediate cause of death Hemorrhage
Subarachnoid Hemorrhage

Duration 24 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy E. Pearson Jr. M. D.
Address St. Josephs Hosp. Date signed Aug 16, 1948

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G65957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G65957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 So. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 So. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris E. Weaver

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Joseph R.
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) Mar 26th 1923
8. AGE: Years 25 | Months 4 | Days 22 | If less than one day: hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Anthony R. Leubott
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Josephine E. Boyle
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Josephine R. Leubott
(b) Address 218 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director Sodaro & Logan Son
(b) Address 701-03 W. Lombard St.

19 AUG 18 1948 (Date rec'd by registrar) Timothy Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17th 1948 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947, to Aug 17 1948, and that I last saw h[illegible] alive on Aug 16 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scognetta M. D.
Address 1729 W. Lombard St. Date signed Aug 17 '48

VS 163

X

A serious error in entry, with one exception, may be corrected only by order of the Court. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

665958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. 665958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Andrea Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN PAWLICKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Mill hand

11. Industry or business Box factory

FATHER
12. Name Michael Pawlicki
13. Birthplace Poland

MOTHER
14. Maiden name Wanda Ematowicz
15. Birthplace Poland

16 (a) Informant Frank Jasinski
(b) Address 425 E Chester

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1 S Bethel St Huntingtown Williams, Md

19 AUG 18 1948 (Date filed by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner

Date signed 8-17-48

X

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure to answer every question. Where information should be entirely supplied, the correct age is especially important.

Homer D. Rich Homer DeWayne Rich

5959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 665959

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richard & Lombard
(c) Hospital or institution: Univ. Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4441 Newport Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Homer D. Rich

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-9051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Homer D. Rich
Edith Bonner Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 24, 1895

8. AGE: Years	Months	Days	If less than one day
52	10	23	hr. min.

9. Birthplace Northfield, Vermont
(Town, county, and state)
10. Usual Occupation Administrative Supt.
11. Industry or business Balmar Corp.

FATHER
12. Name James Hollis Rich
13. Birthplace Vermont

MOTHER
14. Maiden Name Edith M. Ingalls
15. Birthplace Vermont

16 (a) Informant Mrs. Edith Bonner Rich
(b) Address 4441 Newport Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 AUG 18 1948 (Date received by Registrar) (b) Harrington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1948 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1948 to 5-17 1948, and that I last saw he alive on 5-13 1948

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Coronary thrombosis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Howard S. Hall M. D.
Address Univ. Hosp. Date signed 8-17-48

VS 150

Please write plainly with pen or typewriter. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G65960

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Tioga Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Tioga Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY PRAGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1900

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe Maker
11. Industry or business

FATHER
12. Name Rubin Prager
13. Birthplace Russia

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Russia

16 (a) Informant Mr. Robert Prager
(b) Address 3106 Tioga Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Adas Israel Cem.
Location German Hill Road

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington W. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1948, at 7A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1948 to 8/18 1948 and that I last saw h[illegible] alive on 4/28 1948.

Immediate cause of death, Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel J. Schwartz M.D.
Address 2320 Eutaw Pl. Date signed 8/18/48

VS 150

X

65961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 65961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 855 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 855 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hallis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1913

8. AGE: Years	Months	Days	If less than one day
35	3	16	hr. min.

9. Birthplace Henderson, N.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Benjamin Hallis.
13. Birthplace Henderson, N.C.

MOTHER
14. Maiden Name Lucinda Bowman
15 Birthplace Henderson, N.C.

16 (a) Informant William Brooks
(b) Address 855 W. Franklin

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Henderson, N.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1948 at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9, 1948 to Aug 17, 1948 and that I last saw him alive on Aug 17, 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 W. Hill Ave. Date signed 8-18-48

VS 150

665962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 665962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine Carroll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Catherine Carroll
(b) Address 2313 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (mo.) (day) (yr.)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Filing

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 10.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to Generalized A. S. C. V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed August 16, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65963

166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 2 b 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified Colored Man Lawrence William or Same

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced. Unknown

6 (b) Name of husband or wife "

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45? Months Days If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation "

11. Industry or business "

FATHER 12. Name "
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant "
(b) Address "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month)

(c) Cemetery or crematory Potters Field Location Texas Md.

18 (a) Funeral director J. B. Connelly.
(b) Address 418 Eastern Ave.

19 AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 6:19 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of spine and abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-20-48 at 5:00 P M.
(b) Where did injury occur? North Point Blvd. (Bay View Park - P. R. R.)
(c) Did injury occur at home, on farm, industrial place, or public place? industrial place While at work? no
(d) Means of injury Gun shot

23. Signature Edward L. Boyer M.D.
Medical Examiner.
Date signed July 20, 1948

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Its correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G65964

B-121106

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 520 S. Bethel St. (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Russia

3 (a) FULL NAME Alexander Stopczuk (Ostopczuk)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Stopczuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1893

8. AGE: Years 55 Months Days If less than one day hr min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Stopczuk

13. Birthplace Russia

MOTHER 14. Maiden Name Joan?

15. Birthplace Russia

16 (a) Informant Records-Balto. City Hospital

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem. Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1948 to 8-16 1948 and that I last saw him alive on 8-16 1948

Immediate cause of death Carcinoma of stomach 1 yr. — Duration

Due to peritoneal carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. T. Nelson

Address Date signed 8/17/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C65965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C65965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4204 Woodstock Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Woodstock Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE GAY PRICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Mahlon S. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Leetch
13. Birthplace Ireland

MOTHER
14. Maiden Name Lina Mulkins
15. Birthplace New York

16 (a) Informant Mr. Vernon Price
(b) Address 4204 Woodstock Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 18 1948 (Date rec'd by registrar) Huntington for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/28 1947 to 8/17 1948 and that I last saw h[illegible] alive on 8/17 1948.

Immediate cause of death Cerebral hypertension failure — Duration 15 1/2 mos.
Due to Coronary arteriosclerosis
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyamowicz M. D.
Address 1127 S. Paul St. Date signed 8/19/48

VS 150

65966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Register No. 65966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 PARK AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 PARK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLOTTE A. CRAWFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ late JOHN D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1857

8. AGE: Years	Months	Days	If less than one day
91	0	17	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name — YENGLING
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant MRS MILDRED BALLAND
(b) Address 1501 BOLTON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory ST JOHN CATHOLIC
Location WESTMINSTER, MD

18 (a) Funeral director Hann & Withe
(b) Address 410 [illegible] Ave Washington Boulevard

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 16 1948 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 9 1948, to AUG. 16 1948, and that I last saw her alive on AUG. 16 1948.

Immediate cause of death Uremia — Duration 2 days

Due to Hypertension Cardio-Vascular Renal — Duration 4 yrs.

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed Aug 17, 48

VS 190

X

G65967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

Registered No. G65967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 15 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Griffin ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Mary C. Butts

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-14-7089

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Charles S. Butts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 1, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Miller - Corn - Livery
11. Industry or business Factory

FATHER
12. Name John L. Nagle
13. Birthplace Va

MOTHER
14. Maiden Name Mary Blaser
15. Birthplace Va.

16 (a) Informant Eliza Smaltz
(b) Address 1932 Griffin Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Sleepy Creek W. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 8-18 1948 and that I last saw h er alive on 8-18 1948.

Immediate cause of death Cardiac failure

Due to myocarditis

Due to Generalized toxemia from gangrenous cystitis

Other Conditions. Perforation + walled off abscess

(Include pregnancy within 3 months of death)

Date of operation 8/16/48

Major findings of operation: Gangrene cholecystitis + cholelithiasis

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Vernetti Jr MD

Address St. Agnes Hospital Date signed 8/18/48

VS 50

65968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No. 526 - Orchard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 - Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby) Rufus Gibson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 13 1948

8. AGE: Years | Months | Days | If less than one day: hr. min.
5

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Frazier Gibson
13. Birthplace S.C.

MOTHER
14. Maiden Name Lucilla ?
15. Birthplace S.C.

16 (a) Informant Frazier Gibson
(b) Address 526 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director A. Halliday
(b) Address 918 - Druid Hill Ave

19 AUG 19 1948 (Date rec'd by registrar) (b) Washington Ave, Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 18 1948.
and that I last saw him alive on Aug 18 1948.

Immediate cause of death Obstructive jaundice
Duration 2 days.

Due to Congenital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Pinkett M.D.
Address 902 W. Franklin Date signed 8-18-48

10A WING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

665969 665969 Registered No. 665969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751-W. Franklin St
(c) Hospital or institution: University Hosp. 10A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 751-W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Wing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Thompson

13. Birthplace Md.

MOTHER 14. Maiden Name Francis ?

15. Birthplace Md.

16 (a) Informant Chas. Thompson

(b) Address 910- Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory Prot. Calvary.

Location

18 (a) Funeral director W. Halstead

(b) Address 918-Mund Ave

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Wilson, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 48, 19 , at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arterio-Sclerotic C.V.

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil L Rupp M.D. Medical Examiner.

Date signed 15 Aug 48

X

G665970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G665970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if data are available. Physicians: please write the causes of death clearly and legibly. If certificate is incorrectly filled, please supply correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkland St. and Fayette Ave.
(c) Hospital or institution: Mt. Wash. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Whitmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Lee Moog
3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Albert Lee Moog
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1890
8. AGE: Years 57 | Months 9 | Days 20 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name William G. Towers Sr.
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name MARY A. FLINT
15. Birthplace Virginia

16 (a) Informant Mr. Albert L. Moog
(b) Address 828 Whitmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or Crematory Loudon Pk. Cem.
Location Balto. Md.

18 (a) Funeral director W. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 19 1948 (Date rec'd by Dept. of Health) (b) Washington, Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18th 1948, at 12:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13th 1948. to Aug. 18th 1948.
and that I last saw her alive on Aug. 18 1948.

	Duration
Immediate cause of death Cerebral embolism	
Due to: Chronic Rheumatic Heart Disease. Cardiac hypertrophy & dilitation	
Due to: Mitral Stenosis & Incompetency. Bilateral pleural effusion	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mitral stenosis incompetency. Cardiac hypertrophy & dilitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Katherine V. Kemp M. D.
Address Mt. Wash. Gen. Hosp. Date signed Aug. 18th 1948

VS 180

G65971

EB-01688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 107

G65971 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 28 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 7 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Hillsdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Schaefer ELIZABETH R. SCHAEFER ✓

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jean Schaefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1880

8. AGE: Years 68 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Redington (Reddington)
13. Birthplace Pa.

MOTHER
14. Maiden Name Susanna Schermer
15. Birthplace Pa.

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery ~~XXXXXX~~ Loudon
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) Rec'd by Registrar Aug 19 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 7:35 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-19 1948 to 8-18 1948, and that I last saw her alive on 8-18 1948

Immediate cause of death	Duration
Bronchopneumonia, bilat	1 wk.
Due to	
Due to	
Other Conditions Diverticulosis, with perforation into rectum (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Hartung, M.D.
Address Balto City Hosp Date signed 18 Aug 48

VS 193

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 150

G65972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 79 days
(e) Length of stay in Baltimore, (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Marble Hall Road, 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rebecca T. Newbraugh ANN REBECCA NEWBRAUGH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ramsey C. Newbraugh
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): January 6 1905
8. AGE: Years 43 | Months 7 | Days 10 | If less than one day hr. min.
9. Birthplace: West Virginia Martinsburg (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: Charles E. Thompson
13. Birthplace: West Virginia

MOTHER
14. Maiden Name: Grace A. Kershaw
15. Birthplace: West Virginia

16 (a) Informant: Husband
(b) Address: Same as deceased

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Martinsburg, W. Va.

18 (a) Funeral director: Wm. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 19 1948 (Date rec'd by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 4 58 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1948 to Aug. 16 1948, and that I last saw her alive on August 16 1948.

Immediate cause of death: generalized Carcinomatosis — Duration: 2 months
Due to: Carcinoma of breast bilateral — 2 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation May 6 1948
Major findings of operation: Carcinoma of breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Cox 3rd M. D.
Address Union Memorial Hospital Date signed Aug 16 48

VS 150

G65973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 5 mos 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 West 40th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. W. Irving Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~ ~~widowed~~, or ~~divorced~~
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24, 1864

8. AGE: Years	Months	Days	If less than one day
84	5	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name John W. Davis
13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna J. Fields
15. Birthplace St Mary's Co. Md

16 (a) Informant Frances M. Hazard
(b) Address House for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore
Location North Ave at C-94

18 (a) Funeral director John O. Mitchell & Son Inc
(b) Address 1900 Eutaw Place

19 (a) AUG 19 1948 (b) Huntington Williams M.D.
(Accepted by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1948 at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1945 to 8/17 1948, and that I last saw him alive on 8/16 1948.

Immediate cause of death	Duration
Cerebral Vascular Accident (Right)	3 Months
Due to Essential Hypertension	6 years
Due to Arteriosclerosis (Diseased)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Humphreys M. D.
Address 214 Medical Arts Bldg Date signed 8/17/48

VS 150

G65974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

Registered No. G65974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Second St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Second St (If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

3 (a) FULL NAME Laura Ellen Baldwin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Raymond Baldwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1895

8. AGE: Years	Months	Days	If less than one day
53	3	8	hr. min.

9. Birthplace Queens Co Virginia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name William Garnett
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia ?
15. Birthplace Virginia

16 (a) Informant George R. Baldwin
(b) Address 3916 Second St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (Month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Ritchie Hwy. A.A. Co.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) AUG 19 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1948, at 3:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1948, to Aug. 17, 1948, and that I last saw h[illegible] alive on Aug 17 1948.

Immediate cause of death: Circulatory insufficiency — Duration: 6 months

Due to Generalized carcinoma

Due to cancer of the stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1948

Major findings of operation: Cancer of stomach, perforation of stomach

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Neuhauser M. D.
Address 936 Patapsco Ave. Date signed 8-18-48

665975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

665975 Registered No. 51B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 N. Duncan St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 941 N. Duncan St (If outside city or town limits, write RURAL and give town)
(d) Street No. Balt Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kardian

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Kardian
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 19-1883

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Engine Operator
11. Industry or business Shipbuilding

FATHER
12. Name Frank Kardian
13. Birthplace Bohemia

MOTHER
14. Maiden Name Agt Brown
15. Birthplace Bohemia

16 (a) Informant Anna Kardian
(b) Address 941 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Wenck Brandt and Son
(b) Address 902 E Lanvale St

19 (a) AUG 19 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 17 1948, and that I last saw him alive on Aug 17 1948.

Immediate cause of death Carcinoma-Prostate
Broncho-pneumonia
Due to Arteriosclerosis-Generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 3 days.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klimes M. D.
Address 2623 E. Monument St Date signed 8/18/48

VS 150

PLEASE WRITE LEGIBLY. WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95 B

Registered No. G65976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, 324 E. Biddle St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 34

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 E. Biddle St (If rural give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Constantino Procopio

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1895

8. AGE: Years	Months	Days	If less than one day
53	0	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant John Menzer
(b) Address Pheonix, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Ritu Wiedefeld
(b) Address 900 East Biddle St.

19 (a) AUG 19 1948 (Date received by Registrar) (b) Huntington, Indiana, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 14 1948 to August 17 1948 and that I last saw h[illegible] alive on August 17 1948.

Immediate cause of death Cardiac Decompensation

Due to Rheumatic heart disease

Due to

Other Conditions Hydrothorax, enlargement of heart, CHF & lungs, liver

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Nolan, M.D.
Address 5106 Harford Rd Date signed 8/19/48

VS 150

G65977

G65977

OC-48-1332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4 DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. MARINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 2 | Days | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chas. Mariner
13. Birthplace Va

MOTHER
14. Maiden Name Helen Hightower
15. Birthplace Md.

16 (a) Informant Helen Mariner
(b) Address 1030 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co.

18 (a) Funeral director Mr. Robt. D. Elliott & Dan'l Elliott
(b) Address 1129 N. Caroline St

19 (a) AUG 19 1948 (Date rec'd by registrar) Eustace Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection
Status thymico lymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/18/48

VS 181

G65978 #7163

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

Registered No. G65978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Montgomery (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Truett (FRANCES TRUETT)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr) 12-2-41

8. AGE: Years 6 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Ala. - (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name David Truett
13. Birthplace Ala.

MOTHER 14. Maiden Name Ruth Madden
15. Birthplace Ga.

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem.
Location Montgomery Alabama

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 AUG 19 1948 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1948 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug. 18 1948 and that I last saw h[illegible] alive on Aug. 18 1948

Immediate cause of death: CARDIAC FAILURE — Duration: LIFE

Due to TETRALOGY OF FALLOT

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: SAME

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/18/48

YS 15

X

USE WRITING INK, WITH UNDERLINING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

665979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

665979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Fernhill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN ROBINSON

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex White | 5. Color or race Female | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Joseph T. Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1903

8. AGE: Years 44 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Philip Wachter
13. Birthplace Md.

MOTHER
14. Maiden Name Cardine Beck
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John Moll (Sister)
(b) Address 3333 Sussex Road, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 8-18-48

VS 151

65980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65980

170c

FILL WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George EMMETT BURCH

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Barbara

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr): Jan. 27, 1897

8. AGE: Years 51 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business: U.S. Navy Yard

FATHER
12. Name: George Burch
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Jennie Smith
15. Birthplace: Maryland

16 (a) Informant: Mrs Barbara Burch
(b) Address: 1830 N. Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/21/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A. M.
(b) Where did injury occur? Clifton Lake, Clifton Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public Was it at work? No
(d) Means of injury: Auto. ran off road, ran through iron fence and plunged into Lake

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 8/18/48

VS 151

G65981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G65981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 S Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) P
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bednarz
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Angeline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 - 1895

8. AGE: Years 53 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Chicago Ill
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Andrew Bednarz
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Kula
15. Birthplace Poland

16 (a) Informant Angeline Bednarz
(b) Address 416 S Patterson Pk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Bruce Oszewski
(b) Address 1932 Eastern Ave

19 (c) AUG 19 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1948, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1948 to Aug 17 1948 and that I last saw him alive on Aug. 17 1948.

Immediate cause of death Coronary Thrombosis — Suddenly

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
M. D.
Address 408 S. Patterson Park Ave. Date signed 8-17-48

VS 150

X

C65982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

Registered No. C65982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CARROLL HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	10	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Beverly H. Hall
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary Jane Thompson
15. Birthplace Maryland

16 (a) Informant Miss Edna B. Hall
(b) Address 4701 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) AUG 19 1948 (Date rec'd by registrar) by Huntington Williams, MD Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 1.40a.M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-19-48 at 12.45 a.M.
(b) Where did injury occur? Barn at rear of 4701 Harford Road
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury hanged self from rafter in barn

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed August 19, 1948

G65983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G65983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fallsway & Lombard Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan SANDERS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1916

8. AGE: Years	Months	Days	If less than one day
31	10	5	hr. min.

9. Birthplace Blackville, S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Elzie Sanders
13. Birthplace Blackville, S.C.

MOTHER
14. Maiden Name Janie Fuller
15. Birthplace Blackville, S.C.

16 (a) Informant Mabel Taylor
(b) Address 1044 W. Franklin Street

17 (a) Burial (b) Date thereof Augo 20 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 312 W. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 19 48 at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident probably X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8-16-48 1:50 P M.
(b) Where did injury occur? Found: Jones Falls--Fallsway & Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/17/48

VS 151

G65981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓G65984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 744 Waesche Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Waesche St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Suffman.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Estella Suffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1891

8. AGE: Years 57 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Suffman.
13. Birthplace

MOTHER 14. Maiden Name
15 Birthplace

16 (a) Informant Estella Suffman.
(b) Address 744 Waesche St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1948, at 12.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1948 to 8/16 1948, and that I last saw h. alive on 8/15 1948.

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
5 Months

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Carney
Address 23 George St Date signed 8/16/48

VS 150

G65985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G65985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 North Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esline EVALINE OFFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3 1947.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
1	16 4	14		

9. Birthplace Churchton, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Offer.
13. Birthplace Churchton, Md.

MOTHER
14. Maiden Name Mary Williams.
15. Birthplace Elliott City, Md.

16 (a) Informant: Mary Offer
(b) Address 113 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1948. (month) (day) (year)

(c) Cemetery or crematory Int. Auburn
Location

18 (a) Funeral director Mrs. F. R. William.
(b) Address 322 N. Schroeder St.

AUG 19 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 8.50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to confination of Smoke.

Due to

Other Conditions Bilateral bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.

Date signed August 18, 1948

G65986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G65986
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Castle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAURA MARIE FOARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Edwin M. Foard jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1927

8. AGE: Years 21 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace: Wisconsin
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William Bamlett
13. Birthplace: Illinois

MOTHER
14. Maiden Name: Ellen Lawless
15. Birthplace: Ireland

16 (a) Informant: Edwin M. Foard Jr.
(b) Address: 1826 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/1948 (month) (day) (year)

(c) Cemetery or crematory
Location: Beloit, Wisconsin.

18 (a) Funeral director: Flynn & Fleming
(b) Address: 1426 Light Street

19 (a) Date received by registrar: AUG 19 1948 (b) Signature of registrar: for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A. M.
(b) Where did injury occur? Clifton Lake, Clifton Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Auto. missed road, ran through fence and plunged into Lake

23. Signature: [signature] M.D.
Medical Examiner

Date signed 8-18-48

G65987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Castle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Frances Foard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1919

8. AGE: Years 29 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Clerk

FATHER
12. Name: E. Morris Foard
13. Birthplace: 1826 N. Castle St.

MOTHER
14. Maiden Name: Catherine P. Brown
15. Birthplace: Baltimore, Md.

16 (a) Informant: E. Morris Foard
(b) Address: 1826 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Flynn & Fleming
(b) Address: 1426 Light Street.

AUG 19 1948 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 3:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A.M.
(b) Where did injury occur? Clifton Lake, Clifton Pk
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Auto missed rd. ran through fence and plunged into lake.

23. Signature: M.D. (Medical Examiner)

Date signed 8-18-48

A 64 817
G65988
-36-48-0185

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G65988

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Middle River
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S. Randolph Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kenneth Hoke

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-25-48

8. AGE: Years	Months	Days	If less than one day
7	7	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Kenneth Hoke
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Ruden
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St

18 (a) Funeral director Lilly & Zeller
(b) Address 4 & B St Balto

(a) (Date) (b) (Signature of registrar) Lucretia Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948 at 11 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug 17 1948 and that I last saw h[illegible] alive on Aug 17 1948

Immediate cause of death Paroxysmal Dyspnea — Duration
Due to Congenital Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Helpern M.D.
Address JOHNS HOPKINS HOSPITAL (Date signed)

G65989 BALTIMORE CITY HEALTH DEPARTMENT ✓ G65989

AB-119593 CERTIFICATE OF DEATH 12B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1847 Lorman St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Portia Delores Tilghman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21- 1933

8. AGE: Years 15 | Months 4 | Days 23 | If less than one day: hr. min. 15

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Foster
13. Birthplace Va.

MOTHER
14. Maiden Name Ethel Tilghman
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16- 1948 at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1948 to 8-16 1948, and that I last saw him alive on 8-16 1948

	Duration
Immediate cause of death For advanced bilateral pulmonary tuberculosis with extensive cavitation	6 months
Due to with tuberculous laryngitis	2 months
Due to	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at (work)?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 8-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G65990 Registered No. 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 252 N. PINE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Pine ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES R. SMITH

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1879

8. AGE: Years 68 Months 11 Days 1 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Samuel K. Smith

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Adeline

MOTHER 15. Birthplace Md

16 (a) Informant Bertha Smith (wife)

16 (b) Address 651 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

17 (c) Cemetery or crematory Mt Auburn

Location Balto. Md.

18 (a) Funeral director Chas. Herbert

18 (b) Address 570-12 Carroll Station

19 (a) [illegible] (Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1948, to 8-16 1948, and that I last saw him alive on 8-16 1948.

Immediate cause of death PULMONARY TUBERCULOSIS — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.

Address 1824 W Fayette St Date signed 8-17-48

VS 180

X

G65991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G65991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins University 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) D. 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB WEVELO (JACOB NENDEL WEREBLOW)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name HARRY-
13. Birthplace RUSSIA

MOTHER 14. Maiden Name MIRIAM-
15. Birthplace RUSSIA

16 (a) Informant Mrs. Harry BLENNER, Cousin
(b) Address 270 HUNTINGTON ST, NEW HAVEN

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Shalom Mt. Carmel
Location Mimon Hill Rd.

18 (a) Funeral director Jack Levine, Inc.
(b) Address 2100 (702 Eutaw Place) Huntington Wellington, Md.

19 AUG 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 8:00 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? (What kind of work?)
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner
Date signed 8-17-48

VS 151

G65992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH M3D

Registered No. G65992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5901 Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5812 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Passaro

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-8709

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife late Assunta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 1890

8. AGE: Years	Months	Days	If less than one day
58	4		hr. min.

9. Birthplace Busco Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Angelo Passaro

13. Birthplace Italy

MOTHER 14. Maiden Name Anna Suriano

15. Birthplace Italy

16 (a) Informant Anna Ruley (Daughter)

(b) Address 5812 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose

(b) Address 322 S. High St.

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) for Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-48 19 , at 2 20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Coarctation of the Aorta

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John B. Magaddino M.D. Medical Examiner.

Date signed 8-18-48

G65993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G65993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Greene
(b) Street address [redacted]
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name James Graham
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Hester Harley
15. Birthplace S. Carolina

16 (a) Informant Thelma Henry
(b) Address 511 Oxford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-1948 (month) (day) (year)
(c) Cemetery or crematory
Location Lake City, S. C.

18 (d) Funeral director Elmer B. Wilson
(b) Address 1000 Belnitty ave Huntington Station, N.Y.

19 AUG 19 1948 (Date received by Registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 8-17 1948 and that I last saw her alive on 8-17 1948.

Immediate cause of death	Duration
Cardiac arrest failure	
Due to peritonitis	
Due to Perforated carcinoma of ascending colon.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-16-48

Major findings of operation: see diagnosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature John H Rosser M. D.

Address University Hosp. Balto. 1, Md. Date signed 8-17-48

ASL-2

G65994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G65994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. CENTRAL Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUBIN JUDAS GETER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife LETHA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1902

8. AGE: Years	Months	Days	If less than one day
? 46			hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore Md

18 (a) Funeral director Lloyd O. Wilson
(b) Address 1700 Boundary Ave Baltimore Md

19 (a) AUG 19 1948 (Date rec'd by registrar) Registrar's No. 10-2

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 2.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-18 1948, and that I last saw h[im] alive on 8-18 1948.

Immediate cause of death Cerebrovascular accident, right

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 35 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 18 Aug 48

Robert B. McFadden, M.D. Pa

VS 150

G65995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G65995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (If not in hospital) 65 Ellicott Drive
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 65 Ellicott Drive
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry M. Schwabeland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Minnie C.
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) 6-7-1871

8. AGE: Years	Months	Days	If less than one day
77	1	8	— hr. — min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Wholesaler.
11. Industry or business Retired

FATHER
12. Name Andrew Schwabeland.
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Germany

16 (a) Informant Minnie C. Schwabeland
(b) Address 65 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. Bellisher & Son
(b) Address 1700 Eutaw Place

19 (a) (Date received by local registrar) (b) Huntington Williams M.D. Registrar

AUG 19 1948

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug. 15 1948.
and that I last saw him alive on Aug. 13, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	Sudden
Due to Hypertensive cardio-vascular renal disease	2 years
Due to Arteriosclerosis, generalized	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Rudman, M.D.
Address 2517 W. Balto. St. Date signed 8/15/48 M. D.

665996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1631B

Registered No. 665996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Avenue
(c) Hospital or institution: St. Agnes Hosp. 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 DeSota Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA A. FARREN "FREDA A. FARREN"

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-3380

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Thomas J. Farren Sr

6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) 12-22-1895

8. AGE: Years 52 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Housewife & Clerk

11. Industry or business Gordon Dry Cleaning Co

FATHER
12. Name William Hesterberg
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Schange
15. Birthplace Maryland

16 (a) Informant Son—Thomas Farren
(b) Address 16 N. Kossuth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director J. B. Hilbert & Son
(b) Address 1700 Eutaw Place

19 (a) AUG 19 1948 (b) Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 5:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Phenobarbital Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-14-48 at 6:00 P M (?)
(b) Where did injury occur? 121 DeSota Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Ingestion of Phenobarbitol Tablets

23. Signature [signature] M.D. Medical Examiner.
Date signed 8-17-48

VS 191

G65997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G65997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Euclid Ave
(c) Hospital or institution: - - - - - 21 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Euclid Ave
(If rural give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur L. Sullivan "Sullivan"

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Lorine Locke
6 (c) If alive, give age Dec'd years

7. Birth date of deceased (mo., day, yr.) 6-26-1881

8. AGE: Years	Months	Days	If less than one day
67	2	10	20 hr. ... min.

9. Birthplace Tamworth New Hampshire
(Town, county, and state)

10. Usual Occupation Government Food Dept
11. Industry or business Fed. State Health Dept

FATHER
12. Name Gabriel Henry Sullivan
13. Birthplace Boston - Mass

MOTHER
14. Maiden Name Adriana Witteveen
15. Birthplace Rensbroek - Holland

16 (a) Informant Nancy R. Sullivan
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-41 (month) (day) (year)
(c) Cemetery or crematory Ethel Wood
Location Washington D.C.

18 (a) Funeral director T. B. Wilson & Son
(b) Address 1520 Eutaw Place

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16-48 19..., at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Hypertensive Cardio vascular disease

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. McFadden M.D.
Medical Examiner.
Date signed 8-17-48

VS 131

C65998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C65998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hosp. 9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 15 min

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2837 Hillen Rd. (B) (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Marian R Poellman

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ James C. Poellman

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr) Aug 27 1899

8. AGE: Years	Months	Days	If less than one day
48	11	22	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Robt. C. Dudey

13. Birthplace Md.

MOTHER

14. Maiden Name Alice B. Caffrey

15 Birthplace Md.

16 (a) Informant Jas. E. Poellman

(b) Address 2837 Hillen Rd. 8/21/48

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cathedral

Location Balto.

18 (a) Funeral director E. J. Bowling & Son

(b) Address 1938 E. Lafayette Ave

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams Abell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948 at 12 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-1948 to 8-18-1948, and that I last saw h e r alive on 8-18-1948.

Immediate cause of death Acute congestive heart failure

Due to acute coronary thrombosis

Due to

Other Conditions ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: a few hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. D. Thomas, Jr. M. D.

Address Mercy Hosp. Date signed 8-18-48

VS 189

X

G65999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G65999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 70
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schultz

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-01-7289

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Annie Schultz

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1886

8. AGE: Years 61 | Months 10 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Steel Fabricator

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John Schultz
13. Birthplace Germany

MOTHER
14. Maiden Name Henriette Daig
15. Birthplace Germany

16 (a) Informant Katherine Kilgary
(b) Address 947 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George T. Eshcombe
(b) Address 2101 Frederick Ave.

AUG 20 1948 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 7:41 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948, to Aug. 19 1948, and that I last saw him alive on 8/19 1948.

Immediate cause of death Acute cardiac failure

Due to secondary septicemia

Due to Adeno-carcinoma of sigmoid colon.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 29, 1948 - Aug 11, 48

Major findings of operation: Adeno-Ca of Sigmoid Colon

of autopsy: None performed

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen K. Pashman M. D.

Address St. Agnes Hosp. Date signed 8/19/48

VS 150

G66000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 189 Abington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 189 N. Abington Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Frederick Batzer

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Augusta Batzer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25, 1853

8. AGE: Years 95 | Months — | Days 24 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state or foreign country)
10. Usual Occupation Shoemaker
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15 Birthplace Germany

16 (a) Informant Henry Batzer
(b) Address 189 N. Abington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Schnabel
(b) Address 2101 Frederick Ave

19 AUG 20 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 10.04 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1941, to Aug 18 1948 and that I last saw him alive on Aug 18 1948

Immediate cause of death: Arteriosclerosis Cardiac Vascular Disease — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl P. Rosting, M.D.
Address 1316 W. Lombard When signed 8/19/48

VS 150

47-17490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66001

160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legi

E OF DEATH:
altimore City, Maryland

Street address

c) Hospital or institution:
The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2451 Brentwood Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hilliard (1/10951)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Nathaniel Harris
13. Birthplace Unknown

MOTHER
14. Maiden Name Pernice Hilliard
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address The Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 12 1948 to August 13 1948, and that I last saw h im alive on August 13 1948.

Immediate cause of death Subarachnoid Hemorrhages — Duration

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8-12-48

Major findings of operation:

of autopsy: Subarachnoid hemorrhages

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul O Burns M. D.

Address The Johns Hopkins Hospital Date signed 8-16, 48

666002 SC-4P-128-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666002 Registered No. 159

GM. 122026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1416 Millrace Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cooper Baby Girl (Edith)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8- 11- 48

8. AGE: Years Months Days 4 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter Cooper

13. Birthplace Md.

MOTHER 14. Maiden Name Edith Lockner

15. Birthplace Md.

16 (a) Informant Records Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 8am 8-16-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address Contractor Williamsport, Md

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1948 at 1:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-11 1948 to 8-15 1948, and that I last saw her alive on 8-15 1948

Immediate cause of death Prematurity (B. Wt. 7 lbs 9 oz

Duration 3 days

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address B.C.H. Date signed Aug 16

VS 150

X

G66003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66003

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2628 Robb St (If rural give location)

(e) Citizen of foreign country? No ~~Year~~ No

If yes, name country

3 (a) FULL NAME Mrs. William Bill (Cora)

3 (b) If veteran, name war — W

3 (c) Social Security Account No. — None

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William Bill (dead)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 29, 1885

8. AGE: Years 63 | Months 0 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER 12. Name Mr. Henry Smith

13. Birthplace Delaware

MOTHER 14. Maiden Name Marion E. Hart

15. Birthplace Baltimore, Md

16 (a) Informant: Daughter Mrs. Anna Fink

(b) Address (same) 2628 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Wilson Cook Co

(b) Address 1219 E Cold St

19 (Date rec'd by Registrar) AUG 20 1948 Burington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948, to July 19 1948, and that I last saw her alive on July 19 1948.

Immediate cause of death Peritonitis — Duration

Due to Intestinal obstruction & perforation

Due to

Other Conditions Carcinoma of large bowel

(Include pregnancy within 3 months of death)

Date of operation 7/21/48

Major findings of operation: Wound closure

of autopsy: Peritonitis.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)

(e) Means of injury

23. Signature Richard L Beach

Address Union Memorial H Date signed 8/19/48 (M. D.)

VS 150

G66004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 East 21st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 East 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norbin R. Schuldt

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry A. Schuldt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1876

8. AGE: Years	Months	Days	If less than one day
68	2	8	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Frederick Schuldt
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Dinner
15. Birthplace Poland

16 (a) Informant: Henry J. Schuldt
(b) Address 2617 Kingsmith Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1210 E. Fayette Street

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Aug 19 1948, and that I last saw her alive on Aug 17 1948.

	Duration
Immediate cause of death: Uraemia	2-3 days
Due to Glomerular nephritis	5 mos.
Due to Myocarditis & coronary disease.	1 yr.
Other Conditions Goiter.	2 mos.
Arterial Hypertension.	1 yr.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Thomas Graham Manton M. D.
Address 516 Cathedral Date signed 8-19-48

V S 150

G66005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66005
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (County)
(b) City or town Baltimore (If outside city or town, give township or R.F.D. number)
(c) Street No. 1001 St. Paul Street (If rural, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas A. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5th 1883

8. AGE: Years 64 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Cal. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Dunbar Averall
13. Birthplace Maine

MOTHER
14. Maiden Name Lucinda (Unknown)
15. Birthplace Maine

16 (a) Informant Thomas A. Stewart
(b) Address 1001 St. Paul St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month, day, year)
(c) Crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 20 1948 (b) Huntington Williams, M.D. (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/48 19 12:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature John R. Davis, Medical Examiner. M.D.
Date signed 8/19/48

VS 151

G66006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Abbott Ct #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Harry J. Young Jr.

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1935

8. AGE: Years	Months	Days	If less than one day: hr.	min.
13	5	1		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER 12. Name Harry J. Young Sr.
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary C. McLain
15. Birthplace Baltimore, Md.

16 (a) Informant Elmer W. Conklin
(b) Address 924 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 1948 (month) (day) (year)

(c) Cemetery or crematory Jno. Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1948 to 8-19-1948, and that I last saw h[illegible] alive on 8-19-1948

Immediate cause of death Respiratory failure — Duration

Due to Communicating Hydrocephalus

Due to Block at tentorial hiatus

Other Conditions Severe cortical atrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 8-19-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature W A Kleinmann M.D.
Address Univ. Hosp. Date signed 8-19-48

G66007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 879

Registered No. G66007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 W. Henrietta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Ellis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Preston Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1886

8. AGE: Years	Months	Days	If less than one day
62	—	—	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Preston Ellis
(b) Address 155 W. Henrietta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James Castagna
(b) Address 1142 Hollins St

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/48 19 , at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1948, to 8/18 1948.
and that I last saw HER alive on 8/18 1948.

Immediate cause of death	Duration
CEREBRAL EDEMA	
CEREBRAL SCLEROSIS	
Due to GENERALIZED ARTERIOSCLEROSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel A. Scalia
Address So. Balto. Gen. Hosp. Date signed 8/19/48

VS 150

G66008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G66008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N. Potomac St
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Annabelle Roth
6 (c) If alive, give age 68 yrs.

7. Birth date of deceased (mo., day, yr) April 27, (1881)

8. AGE: Years	Months	Days	If less than one day
67 68	3	21	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Roth
13. Birthplace Germany.

MOTHER
14. Maiden Name Katherine Lampe
15. Birthplace Germany

16 (a) Informant Mrs Annabelle Roth
(b) Address 10 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St. Huntington Station Baltimore, Md

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948 at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1948, to Aug 17 1948, and that I last saw him alive on Aug 17 1948.

Immediate cause of death Cardiac asthenia. — Duration 2da

Due to Cerebral Hemorrhage — 6 da

Due to Hematuria — 4 da

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature E M Townsend M.D.
Address 1307 St Paul St Date signed Aug 19 1948.

VS 150

G66009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 N. Luzerne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) approx 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Luzerne Ave.,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME IDA SIEGEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	6	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Jacob Siegel
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Rose
15. Birthplace unknown

16 (a) Informant Miss Carrie Siegel - sister
(b) Address 535 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Congregation
Location Belair Rd., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) AUG 20 1948 (Date received by registrar) Huntington Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18- 1948, at 2.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17- 1948, to 8-18- 1948, and that I last saw h/e alive on 8-18- 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: hypertension — 2 years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8-19-48

C66010

121262 I.D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C66010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Peel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-? 60?

8. AGE: Years 60? | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals - Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 16 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1948 at 9.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14- 1948, to 7-15- 1948, and that I last saw him alive on 7-15- 1948.

Immediate cause of death: CVA — Duration 12hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.

23. Signature M. D. Nelson M.D.
Address Baltimore City Hospitals Date signed 8/1/48

G66011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James KIETH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 16 1948
Commissioner of Health

18 (a) Funeral director

(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948, at 9 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined (decomposed)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 8/16/48

G66012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. H. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidore C Lapin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory

Location University Medical School AUG 16 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 August 1948, at 6:10? M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner
Date signed 9 Aug. 1948

VS 151

66013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101
(c) Hospital or institution: John Hopkins Hospital 3d
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4336 Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Watnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90				

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (mo., day, yr.)
(c) Cemetery or crematory
Location University Medical School AUG 16 1948 Commissioner of Health

18 (a) Funeral director
(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 19 48 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic P.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? White or work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8/16/48

G66014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write GENERAL and give town)
(d) Street No. 667 West Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER POWELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)

(c) Cemetery or crematory

Location University Medical School AUG 16 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 20 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/48 19 at 2015 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work)
(d) Means of injury

23. Signature John R Peers M.D.
Medical Examiner.
Date signed 8/10/48

VS 151

Breston H. Resau

666015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 666015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1273 E North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1273 E North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Breston H. Resau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jona Resau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1877

8. AGE: Years 70 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto Co
(Town, county, and state)

10. Usual Occupation Machinist (Retired)

11. Industry or business

FATHER
12. Name H H Resau
13. Birthplace Md

MOTHER
14. Maiden Name Sophia Knapp
15. Birthplace Md

16 (a) Informant Miss Evelyn Resau
(b) Address 1273 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 20 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 18 1948 at 4 05 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory failure

Due to Hypertensive Cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. R. McFadden M.D.
Medical Examiner.
Date signed 8-19-48

VS 191

G66016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66016 / 82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 565 Lanvale St (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country none

3 (a) FULL NAME Margaret Smith

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel Smith
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) 2/2/1882

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Ward Penn Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business none

FATHER
12. Name Travis Flowers
13. Birthplace ?

MOTHER
14. Maiden Name Jane Flowers
15. Birthplace ?

16 (a) Informant Samuel Smith, Husband
(b) Address 565 Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 19 48, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948, to 8-17 1948, and that I last saw h alive on 8-17 1948.

Immediate cause of death Cerebral hemorrhage
(Cerebral vascular accident)
Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. L. Boyd M. D.
Address Provident Hosp Date signed 8-19-48

VS 150

G66017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G66017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital DOA
(d) Length of stay in hospital or instt. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Lafayette St. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Daisy White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Albert White
13. Birthplace Md.

MOTHER
14. Maiden Name Hettie Cooper
15. Birthplace Md.

16 (a) Informant: Mrs. Daisy White
(b) Address 543 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 20 1948 (Date received by local registrar) (b) Huntington Williamson Jr. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 7:10PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 8/19/48

VS 151

G66018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66018 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William WEAVER (Wm. D. Weaver)

3 (b) If veteran, name war —

3 (c) Social Security Account No. ---

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva Weaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1881

8. AGE: Years 66 | Months 10 | Days 21 6 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Wm. Weaver
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: N.C.

16 (a) Informant: Emil Weaver
(b) Address: 2100 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20/48 (month, day, year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henry Sons
(b) Address: 2024 Orleans St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 11:45 M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease.

Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 8/19/48

VS 151

G66019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 471

G66019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VIRGINIA (b) County
(c) City or town RICHMOND (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 GROVE AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME DR. OLIVER BRUNK

3 (b) If veteran, name war World War #1
3 (c) Social Security Account No. [redacted]

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife BERNICE
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 9-13-78

8. AGE: Years 69 | Months 11 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation PHYSICIAN

11. Industry or business

FATHER
12. Name CHRISTIAN BRUNK
13. Birthplace VA.

MOTHER
14. Maiden Name MARY RALSTON
15. Birthplace VA.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Va.

18 (a) Funeral director E. J. Tisdale & Son Inc.
(b) Address 800 W. Grace St. Richmond Va.

19 AUG 20 1948 (Date rec'd by registrar) (b) Huntington, W. Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1948 to 8-19 1948
and that I last saw him alive on 8-19 1948

Immediate cause of death Empyema, left Chest with Broncho-pleural Fistula & Abcess, Right lower lobe — Duration 2 Months 3 weeks

Due to Carcinoma, Left Lung (Removal at Operation, April 1948) — Duration 6 months

Other Conditions Arteriosclerosis — Duration years

(Include pregnancy within 3 months of death)

Date of operation August 18, 1948

Major findings of operation: Empyema, Left Chest & Broncho-pleural Fistula

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Chesney M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/19/48

G66020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G66020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM PETERS Vasilios Prodromou

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-28-2072

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Despina

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Prodromou

13. Birthplace

MOTHER 14. Maiden Name Stamatia

15. Birthplace

16 (a) Informant Kyriakos Prodromou

(b) Address 1400 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)

(c) Cemetery or crematory Greek Cemetery

Location Windsor Mill Rd.

18 (a) Funeral director Lambros Inc

(b) Address 440 E. North ave

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 10.10 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Medical Examiner M.D.

Date signed August 18, 1948

VS 131

G66021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66021 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate before body is removed. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore City. Md
(b) Street address 33rd & Colvert Street
(c) Hospital or institution: Union Memorial Hosp. 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Garrison Boulevard. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Porter Hatter — Frank Porter Hatter

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-6577

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Charlotte P. Hatter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1879

8. AGE: Years 69 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Accountant.

11. Industry or business

FATHER
12. Name Charles W Hatter
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Porter
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs. Charlotte P. Hatter
(b) Address 3112 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves. Balto, 17

19 (a) AUG 20 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 19 1948, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 15 1948 to Aug - 19 1948, and that I last saw him alive on Aug 19 1948.

Immediate cause of death	Duration
Cardio - Respiratory Failure	5 days
Due to Coronary Insufficiency	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr. M.D.
Address Union Memorial Hosp. Date signed 8/19/48

VS 150

G66022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Guilford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Florence M. Leizear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James Edmund Leizear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/ /1882

8. AGE: Years 66 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel D. Myers
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Frances Eader
15. Birthplace: Frederick Co. Md.

16 (a) Informant: Mrs. Ethel L. Herzer
(b) Address: 7111 Sheffield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn, Md.

18 (a) Funeral director: William J. Tickner & Sons,
(b) Address: North & Pa. Aves.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Tickner & Williams, Mgrs.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948, to Aug. 18 1948, and that I last saw h GR alive on Aug. 18 1948.

Immediate cause of death: Heart failure & Circulatory failure — Duration

Due to: Cornary Seculain

Due to: Arteriosclerosis

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William S. Warnicke M. D.
Address Bon Secours Hosp. Date signed 8/18/48

VS 180

G66023

AB-95807

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓ Registered No. G66023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs
(e) Length of stay in Baltimore (yrs., mos., or days) ? 2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME James Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-?

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 19 1948
Commissioner of Health

18 (a) Funeral director
(b) Address AUG 20 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9- 1948, at 8A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-31- 1945 to 8-9- 1948, and that I last saw h in alive on 8-9- 1948

Duration
1 day
6 days
yrs

Immediate cause of death Bronchopneumonia
Due to
Due to and Cerebrovascular Accident
Other Conditions Hypertensive and Arteriosclerotic Cardiovascular Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren E. Rice M.D.
Address Balto City Hospitals Date signed 8/13/48

53a

G66024 JL - 121426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

Registered No. G66024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1040 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 211 China St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1907

8. AGE: Years	Months	Days	If less than one day
41	4	25	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Jefferson
13. Birthplace S. C.

MOTHER
14. Maiden Name Dorothy Stool
15. Birthplace S. C.

16 (a) Informant B.C.H. Records
(b) Address 1040 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School AUG 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) Filing

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1948, at 2:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 22 1948 to Aug. 7 1948, and that I last saw her alive on Aug. 7 1948.

Immediate cause of death Advanced pneumonia right, probably due to tuberculosis — Duration 3 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. Stutzman M. D.

Address Balto. City Hosp. Date signed 8-14-48

VS 150

Dr. Brennan

666025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G666025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET A. PUHL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Herman W. Puhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 17, 1878

8. AGE: Years	Months	Days	If less than one day
70	1	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick J. Hesse
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Thurne
15 Birthplace Germany

16 (a) Informant Mrs. Lillian H. Bringman
(b) Address 3019 Echodale Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 20 1948 (Date received by registrar) (b) Twitty for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Aug 1948, and that I last saw her alive on Aug 19 1948.

Immediate cause of death Cardiac failure — Duration

Due to Generalized Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 8-19-48

VS 150

G66026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73

Registered No. G66026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Dudley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Dudley Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country England 38 years

3 (a) FULL NAME Henry Murphy

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-4571

4. Sex M | **5. Color or race** W. | **6 (a) Single, ~~married~~ widowed, or ~~divorced~~.**

6 (b) Name of husband or wife Rosella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 12-1875

8. AGE: Years 73 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business Standard Oil

FATHER
12. Name
13. Birthplace England

MOTHER
14. Maiden Name —
15. Birthplace England

16 (a) Informant Mrs Catherine Kerr
(b) Address 3222 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos D Iden & Son
(b) Address 3001 Kentucky Ave

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-48 19 , at 4:46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to 8-18-48 19 , and that I last saw h~~e~~ alive on 8-18-48 19 .

Immediate cause of death Aplastic Anaemia — **Duration**

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J McGrath
Address 1E. Randall St Date signed 8/19/48

Dr. J. McGrath X

G66027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. G66027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 E. Gittings Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James V. Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Lennie C

6 (b) Name of husband or wife: Lyon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1897

8. AGE: Years 50 | Months 10 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Park Doors

11. Industry or business

FATHER
12. Name Benjamin A. Hooker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lelia Smith
15. Birthplace Baltimore Md

16 (a) Informant Mrs J. V. Hooper
(b) Address 107 E. Gittings St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48
(c) Cemetery or crematory Lauren Park
Location Redeemer Area

18 (a) Funeral director J. B. Foley & Sons
(b) Address 18 & Light St

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 8:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull with intracranial hemorrhage

Due to Street fight

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15- at 3.20 P. M.
(b) Where did injury occur? 1442 Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Saloon) (While at work) no
(d) Means of injury Struck by fist & knocked to pavement.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8-19-48

VS 151

WASILJOV

G66028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G66028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wasiljov

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Wasiljov
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 - 1882

8. AGE: Years: 66 | Months: 4 | Days: 8 | If less than one day: hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Hochschild Kohn & Co.

FATHER
12. Name Mary Wasiljov, Nicholas
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna KERSCHNER
15. Birthplace Hungary

16 (a) Informant Mrs Mary Wasiljov
(b) Address 230 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Riverside Highway

18 (a) Funeral director J. J. Fahey & Son
(b) Address 1318 Light St.

19 (a) AUG 20 1948 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/48 19 . at 1.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948. to 8/19 1948.
and that I last saw h alive on 8/19/48 19

Immediate cause of death Acute Pancreatitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 8-19-48

MacDonald

VS 150

G66029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Lancaster St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Lancaster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Slaba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Wojciech Slaba
13. Birthplace: Poland

MOTHER
14. Maiden Name: Olszewska
15. Birthplace: Poland

16 (a) Informant: Agnes Slaba
(b) Address: 1609 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 21/58 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Baltimore

18 (a) Funeral director: Fred W. Ozmun
(b) Address: 1930 Eastern Ave.

19 (a) AUG 20 19[illegible] (Date received by registrar) [illegible] for Holloway Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw him alive on 8/18/ 1948.

Immediate cause of death: Malignancy intestinal — Duration: 2 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Dr. Eduard Novak per M. T. Boyd M. D.
Address: Date signed

66030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. 66030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Ida Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/27/1882

8. AGE: Years	Months	Days	If less than one day
66	6	21	hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Stewart
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Georgie Anna Stewart
15. Birthplace Harford Co. Md

16 (a) Informant Pierson Wilson
(b) Address 1912 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Aberdeen
Location Aberdeen, Md

18 (a) Funeral director Leo B. Kelly
(b) Address 1203 Presstman St

19 AUG 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1948 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1948 to 8/17 1948 and that I last saw her alive on 8/17 1948.

Immediate cause of death	Duration
Pancreatic Abscess	
Due to Ventral Hernia —	
Due to Intestinal Obstruction	
Other Conditions Arteriosclerosis Uremia Cardiovascular Dis — (Include pregnancy within 3 months of death)	

Date of operation 8/13/48 - 8/15/48

Major findings of operation: Ventral Hernia Intestinal obstruction

Findings of autopsy: Pancreatic Abscess

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore Sr M.D.
Address Provident Hospital Date signed 8/20/48

VS 150

666031

GK 122138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93 D

666031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md/ (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Flora Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Golden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ?

8. AGE: Years	Months	Days	If less than one day hr.	min.
68 ?				

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name John Golden
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Presstman St

19 (a) (b) Registrar

AUG 26 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1948 to 8-19- 1948
and that I last saw her alive on 8-19- 1948

Immediate cause of death Cerebral vascular accident, left — Duration 3 days

Due to Hypertensive Cardio-vascular disease — 2-3 years

Due to

Other Conditions Bronchopneumonia, left lower lobe. — 3 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute Bronchopneumonia, left

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 8-20-48

EB-122209 G66032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 159

Registered No. G66032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) N.B.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 18, 1948

8. AGE: Years 1 day | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Hilda Chucker
15. Birthplace Va.

16 (a) Informant RECORDS: Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. County Md.

18 (a) Funeral director Thos. Corbin Edmondson
(b) Address 1129 N. Caroline St

19 AUG 20 1948 (Date rec'd by registrar) (b) Hunting for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 48 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-19 1948
and that I last saw him alive on 8-19 1948

Immediate cause of death Prematurity

Duration 12 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed Aug 19 48

G66033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66033
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 E. 39th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 E. 39th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard O. Buffington

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary C. Buffington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	24	hr. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation: Seed Merchant Wholesale
11. Industry or business: Retired 20 years

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name: Anna White
15. Birthplace: Md.

16 (a) Informant: Mr. Howard O. Buffington, Jr.
(b) Address: 1338 Crofton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director: William J. Tickner & Sons,
(b) Address: North & Pa. Aves. Balto. 17

19 (a) Huntington Williams (Registrar)
(Date rec'd by registrar) AUG 21 1948
VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939 to Aug. 18 1948, and that I last saw him alive on July 23 1948.

Immediate cause of death: Coronary thrombosis — Duration: Sudden

Due to: Arteriosclerosis — Duration: yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt. B Wright M. D.
Address Medical Arts Bldg. Date signed 8/19/48.

G66034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59B

G66034
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. 29th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel A. Wise (ETHEL A. WISE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph R. Wise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 22 75

8. AGE: Years 72 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Dominick Hayden
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Howard
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave

AUG 20 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 7 45A M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/21 1948 to 8/18 1948, and that I last saw her alive on 8/8 1948.

Immediate cause of death Gangrenous rt. leg & foot. — Duration 10+ yrs.

Due to Arteriosclerosis, gen., severe

Due to

Other Conditions Osteoarthritis, severe
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature E. M. Smith M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/19/48

VS 195

97

G66035

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G66035

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Waterloo Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JESSE DASHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-1886

8. AGE: Years 62 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Penn West Virginia (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Jesse V.S. Dasher
13. Birthplace Penn. W. Va

MOTHER
14. Maiden Name Hannah M Cowger
15. Birthplace Fort Lyburn W Va

16 (a) Informant M Dasher
(b) Address Moyfield W Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)

(c) Cemetery or crematory Taylorsville
Location Taylorsville LAYTONSVILLE

18 (a) Funeral director C C Hezenbottom
(b) Address Ellicott City Md

19 AUG 20 1948 (Date rec'd by Registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 6.50PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage,

Due to

Other Conditions Multiple brush burns and bruises (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-48 at approx. 1.35AM.
(b) Where did injury occur? half a mile north of Rt. 175 on Wash. Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury truck and truck collision

23. Signature Thomas J. Mullins M.D. (Medical Examiner)
Date signed August 18, 1948

VS 151

G66036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G66036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Any supplied should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1948

8. AGE: Years 28 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Lt. Worker

11. Industry or business

FATHER
12. Name Daniel Johnson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ethel Brown
15. Birthplace Baltimore Md

16 (a) Informant Edgar Johnson
(b) Address 1170 Bet Ale Eldevy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandywine

19 (a) AUG 20 1948 (Date filed by registrar) Hunting ton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948, at 6.45 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-48 at approx. 6 P.M.
(b) Where did injury occur? B & O R.R. siding at Potte St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? No
(d) Means of injury Fell overboard

23. Signature M.D.
Medical Examiner.
Date signed August 16, 1948

VS 15t

G66037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Bracken

3 (b) If veteran, name war: No

(c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b). Name of husband or wife: Mary E. Bracken
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9. 1906

8. AGE: Years	Months	Days	If less than one day
42	6	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Plumbing Business

FATHER
12. Name John F. Bracken
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie C. Wendt
15. Birthplace Germany

16 (a) Informant: Mrs. Mary E. Bracken
(b) Address 506 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1948 (month) (day) (year)
(c) Cemetery or crematory Morland Park Cemetery
Location: Taylor Ave. Dalesland Rd.

18 (a) Funeral director Edgar W. Conklin
(b) Address 2201 E. Eager St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Aug. 1948, at 12.45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 20 Aug. 1948

G66038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66038 Registered No.

GM.121228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if unknown, so state. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] MARY BARBARO

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April- 22- 1867

8. AGE: Years 81 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name DOMINIC BARBARO
13. Birthplace ? ?

MOTHER
14. Maiden Name CHRISTINE ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-21-48. (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM. Location GERMAN HILL RD.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) AUG 20 1948 (Date received by registrar) (b) [illegible]

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19- 1948 at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 13- 1948 to 8- 19- 1948, and that I last saw her alive on 8- 19- 1948

Immediate cause of death Bronchopneumonia — Duration 9 days

Due to Cerebral Vascular Accident — 5 weeks

Due to Hypertension Arteriosclerotic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Vieler J. M. D.
Address Balto City Hosp Date signed 19 Aug 48.

G66039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G66039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Have correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Leadenhall Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Leadenhall Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/19/1880

8. AGE: Years	Months	Days	If less than one day
68 67	3	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Baltimore, Md,

MOTHER
14. Maiden Name Charlottie Hopkins
15. Birthplace Virginia

16 (a) Informant Ida Smith
(b) Address 804 Leadenhall Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, City.

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 108 W. Preston [illegible] St. Baltimore, Md.

19 (a) Date received AUG 24 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 12-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1948 to 8-18 1948, and that I last saw him alive on 8-18 1948.

Immediate cause of death Myocardial degeneration — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Franklin Culkin M. D.
Address 1543 Penna. Ave Date signed 8/20/48

G66040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G66040

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 722 S. Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William H. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lena Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February, 1898

8. AGE: Years	Months	Days	If less than one day hr.	min.
50	6			

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Western Md. Coal Pier Co.

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Anna Wheeler

15. Birthplace Virginia

16 (a) Informant Lena Johnson (W)

(b) Address 722 S. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W. Montgomery Street

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/48 19 at 7 15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/15/48 19 to 8/18 19 48. and that I last saw h i m alive on 8/15 19 48.

Immediate cause of death Portal cirrhosis 2 months

Due to ascites

Due to

Other Conditions Chronic pyelonephritis ? mo.

arteriosclerosis

(Include pregnancy within 3 months of death)

Duration ? mo.

Date of operation

Major findings of operation:

of autopsy as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Glenn O. Summerlin M. D.

Address So. Balto. Gen. Hosp. Date signed 8/19/48

VS 150

G66041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G66041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 17 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 111 S. Spring St. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM TOWNSEND

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: 212-22-6118

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Mary Townsend
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 12, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	1	7		

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: John Townsend
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Martha Cox
15. Birthplace: Maryland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof: Aug 23. 1948 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Finleyville, Pa.
18 (a) Funeral director: Rudel Fishpool
(b) Address: 312 E. Highland Ave.
(c) (b) Huntington W. Va.

AUG 20 1948 (Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1948, at 12:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 2 1948 to Aug. 19 1948, and that I last saw him alive on Aug. 19 1948.

Immediate cause of death: Probable carcinoma of left breast with metastases — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury:
23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 8/19/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

G66042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66042 Registered No. 124a

B-122118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of items is required by law. Any person who knowingly supplies false information or who willfully neglects or refuses to supply correct information is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 (48) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) 1
(d) Street No. 323 Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1900

8. AGE: Years 47 (48) | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Bondro
15. Birthplace Md.

16 (a) Informant RECORDS-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Location Catonsville Md.

18 (a) Funeral director Wendell Sherpel
(b) Address 312 S. Highland Ave

19 (a) 8 1948 (Date received by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1948, to 8-18 1948, and that I last saw him alive on 8-18 1948.

Immediate cause of death: Rupture of esophageal ulcer ?
Due to: Cirrhosis
Due to: alcoholism ?

Duration

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Nolan, M.D.
Address Date signed 8/18/48

G36043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly as possible. Date of death and age at death are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Foot of Boston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County Salem
(c) City or town Elmer
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Flanagan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
M	W	Married

6 (b) Name of ~~husband~~ or wife May Smith Flanagan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1927

8. AGE:	Years	Months	Days	If less than one day
	21	0	12	hr. min.

9. Birthplace Elmer N. J.
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Harry Flanagan
13. Birthplace Auburn N. J.

MOTHER
14. Maiden Name Clarissa Mickle
15. Birthplace Deerfield N. J.

16 (a) Informant B. L. Cristy
(b) Address Elmer N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month, day, year)
(c) Cemetery or crematory Dare Town Presbyterian
Location " N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 217 S. Red St.

19 AUG 20 1948 (Date rec'd by Registrar) [illegible] Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 20, 1948, at 11:05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were probable

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 19, 1948
(b) Where did injury occur? Foot of Boston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Drowning

23. Signature Geo. G. Merrill M.D.
Medical Examiner.
Date signed 8-20-48

VS 151

G66044 Bal 6
471316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
52a

G66044
Registered No.

PLEASE WRITE PLAINLY, with unfading ink, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil Co
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 W High St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Trimble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martin
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 5-8-86

8. AGE: Years 62 | Months 3 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Trimble
13. Birthplace Pa.

MOTHER 14. Maiden Name Eliza ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Elkton
Location Elkton, Md

18 (a) Funeral director H. W. Pusey & Son
(b) Address Elkton Md

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20- 1948, at 3:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1948 to 8-20 1948
and that I last saw him alive on 8-20 1948

Immediate cause of death: Coma + Shock — Duration

Due to: Carcinoma of rt Kidney

Due to: ? Hypernephroma.

Other Conditions: ? Cerebral metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Cause of autopsy: Ca of Kidney.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

G66045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Linden Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Southampton
(c) City or town Saltville Va (If outside city or town limits, write RURAL and give township) Smyth Co
(d) Street No. Saltville Rt 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Wiley Luther Williams

3 (b) If veteran, name war None

3 (c) Social Security Account No. — ?) —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Virginia Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) About 1884

8. AGE: Years: About 64 | Months: 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Pipe Fitter

11. Industry or business: Madison Alkali Co

FATHER
12. Name: Thomas W Williams
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Elizabeth Frader
15. Birthplace: Virginia

16 (a) Informant: Louis E Williams (son)
(b) Address: 1721 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-48 (month) (day) (year)
(c) Cemetery or crematory: Saltville
Location: Saltville Va.

18 (a) Funeral director: Stuart Moore Co.
(b) Address: 108 W 27th Ave

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Funeral for Williams, Mr

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Aug 1948 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to 20 Aug 1948, and that I last saw h[illegible] alive on 19 Aug 1948.

Immediate cause of death: Acute Lymphatic Leukemia — Duration: 5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Langston L Lewis M.D.
Address 938 Linden Ave Date signed 20 Aug 1948

VS 150

666046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 666046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 1 to 23 is complete and correct. Accuracy in stating age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4014 Bonner Road
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4014 Bonner Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME STELLA OBERMANN

3 (b) If veteran, name war ********
3 (c) Social Security Account No. 214-01-2757

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 9 - 1890

8. AGE: Years	Months	Days	If less than one day
57	9	9	********** min.

9. Birthplace Millwaukee Wiscon. (Town, county, and state)
10. Usual Occupation ------
11. Industry or business ------

FATHER
12. Name Phillip Obermann
13. Birthplace Wiscon.

MOTHER
14. Maiden Name Pauline Bellman
15. Birthplace Wiscon.

16 (a) Informant Miss Cora Obermann
(b) Address 4014 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director P. B. Hebbert & Son
(b) Address 1300 EUTAW PLACE. ..17.

19 (a) AUG 21 1948 (b) Huntington Williams, M.D.
(Registrar) (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 18th. 1948 4:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from May 28 19 to Aug 18 19 48, and that I last saw her alive on Aug 17 19 48

Immediate cause of death Carcinoma Uterus — Duration about 5 yrs

Due to

Due to Metastasis in liver tote

Other Conditions Anemia secondary — about 6 mo

(Include pregnancy within 3 months of death)

Date of operation 1943

Major findings of operation: Carcinoma of uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hollis D. Hulett M. D.
Address Garrison Blvd. Date signed

VS 150

G66047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66047

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2005 W. Lanvale St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2005 W. Lanvale St
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Mary Green

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug. 10, 1872

8. AGE: Years 76 | Months - | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business .....

FATHER
12. Name John Lindeburg
13. Birthplace Md.

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant Mrs. Florence Johnson

(b) Address 2005 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 5708 W. Biddle St.

19 (a) AUG 21 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 19, 1948 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Aug 19 1948, and that I last saw h[illegible] alive on Aug 18 1948.

Immediate cause of death Enterocolitis

Due to Heart Disease.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration 7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature William M. Carnes M. D.

Address 753 Cargill Date signed 8/30/48

VS 150

G66048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66048 / 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: Emmanuel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Brown

3 (b) If veteran, name war

3 (c) Social Security Acct. No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	5	22		

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Hall
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Arthur R. Johnston
(b) Address 2539 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Liberty Cem.
Location Harford Co. Md.

18 (a) Funeral director Thos. Kemp & Son
(b) Address 1631 Druid Hill Ave.
Huntington Williams, Registrar

AUG 21 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1948 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, to Aug 1 1948
and that I last saw her alive on Aug 1 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 2134 Druid Hill Ave. Date signed Aug 2 1948 M.D.

VS 150

G66049 PEAKER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No. G66049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Joseph Peaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
52	1	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Peaker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name [illegible]
15. Birthplace Baltimore, Md

16 (a) Informant [illegible]
(b) Address 1409 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. H. Goldsborough
(b) Address 1631 Druid Hill Ave

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18, 1948, at 11:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1947, to 8-18 1948, and that I last saw him alive on 8-18 1948.

Immediate cause of death Carcinoma of Stomach with wide spread metastasis - gastrectomy, [illegible]

Due to (or as a consequence of) Generalized arteriosclerosis; Coronary [illegible] and nephrosclerosis

Other Conditions Embolism and Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simon N. Carter, jr. M.D.
Address Provident Hospital Date signed 8-20-48

G66050

48-03 32)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (1950)

Registered No. G66050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD A. ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1948

8. AGE: Years | Months 6 | Days 4 | If less than one day hr min.

9. Birthplace Balto Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Matthew Drake

13. Birthplace N. Carolina

MOTHER 14. Maiden Name Evelyn Robinson

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Alice Robinson (Exfather)

(b) Address 1528 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1948 (month, day, year)

(c) Cemetery or crematory Pleasant Rest.

Location Towson, Md.

18 (a) Funeral director Mrs. George A. Wells

(b) Address 1431 Druid Hill Ave.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 8:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)

by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

due to aspiration of vomitus

Other Conditions Intestinal obstruction due to mesenteric hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-19-48 Approx. 7:00 P M.

(b) Where did injury occur? 628 W. Lexington Street

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Aspiration of vomitus

23. Signature [signature] M.D. Medical Examiner.

Date signed 8-20-48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Do not abbreviate. Use full name of city or county. Do not use ditto marks. If birthplace is unknown, write "Unknown." If deceased was married, widowed or divorced, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G66051

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 W. Carey St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Spelman Rd CHERRY HILL (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Washington

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1898

8. AGE: Years	Months	Days	If less than one day
50	1	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Washington
13. Birthplace Va

MOTHER
14. Maiden Name Susan Washington
15. Birthplace Va

16 (a) Informant Clara Johnson
(b) Address 2903 Spelman ave Cherry Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location 66 A Co

18 (a) Funeral director Raymon Sanders
(b) Address 1419 E. Preston St

19 AUG 21 1948 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1948 to Aug 18 1948 and that I last saw h[illegible] alive on Aug 17 1948.

Immediate cause of death Uraemia Coma — Duration 2 days

Due to Chronic Interstitial Nephritis — Duration 1 year

Due to Hypertension — Duration [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(a) Date of occurrence at M
(b) Where did injury occur? (City or town) (County) (State)
(c) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(d) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/19/48

X

G66052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G66052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 St. Paul Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RACHAEL MERLEES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Martin Merlees
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 ?

8. AGE: Years	Months	Days	If less than one day
about 70			hr. min.

9. Birthplace Stavanger, Norway (Town, county, and state)
10. Usual Occupation masseuse
11. Industry or business

FATHER
12. Name Abraham Topdahl
13. Birthplace Stavanger, Norway

MOTHER
14. Maiden Name ?
15. Birthplace Stavanger, Norway

16 (a) Informant Einar Merlees
(b) Address 1106 Andover Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) AUG 21 1948 (Date rec'd by registrar) Transcribing for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 19 48 at 4:35 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to carbon monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-19-48 at 3:00 P M.?
(b) Where did injury occur? 2811 St. Paul St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners on on stove but unlit

23. Signature Robert E. McFadden, M.D. M.D.
(Medical Examiner)
Date signed 8-20-48

660053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

660053 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 E. Montgomery St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 E. Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Eugene Butler

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 13, 1876
8. AGE: Years 72 | Months 6 | Days 6 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Glass Co.

FATHER
12. Name Edward H. Butler
13. Birthplace Md

MOTHER
14. Maiden Name Georgiana Crandall
15 Birthplace Md

16 (a) Informant Bernard E. Butler
(b) Address 112 E. Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd

18 (a) Funeral director John F. Kenny Inc
(b) Address 755 Light St.

19 (a) AUG 21 1948 (Date rec'd by Registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6, 1948 to Aug 19 1948 and that I last saw him alive on Aug 19 1948.

Immediate cause of death: Chronic myocarditis with edema — Duration: 15 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Peterman
Address 1226 Hanover St Date signed M D 8/20/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

660054 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Hamilton Ave Apt 14 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Westerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Deceased | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1874 (If less than one day hr. min.)

8. AGE: Years 74 | Months 2 | Days 25

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None (Retired)

11. Industry or business

FATHER
12. Name William Westerman
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kellman
15. Birthplace Germany

16 (a) Informant Deceased
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-22-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk
Location Taylor Ave.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St

19 (a) AUG 21 1948 (Date received) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 — 1948 at 1:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 20, 1948 to Aug. 20 1948 and that I last saw him alive on 8-19-1948

Immediate cause of death: Uremia — Duration 2 wks.

Due to: Renal Failure — 2 wks.

With Vesical Neck Obstruction, Pyelitis and Pyelonephritis — 1-2 weeks

Other Conditions Adenoma of Prostate, Cancerous change

(Include pregnancy within 3 months of death.)

Date of operation 7-27-48

Major findings of operation: Enlarged Prostate gland.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature C. W. Thomas M.D.

Address Mercy Hosp. Date signed 8-20-48

VS 150

G66055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY R POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-1882

8. AGE: Years 66 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James F. McGowan
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth J. Feaney
15. Birthplace Delaware

16 (a) Informant James F. McGowan
(b) Address 2513 Market St Wilm Del

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 8-23-48 (month)
(c) Cemetery or crematory Cathedral
Location Wilmington Del

18 (a) Funeral director John J. Moran
(b) Address 3600 E. Baltimore St

19 (a) AUG 21 1948 (Date received by registrar) (b) Burlington Wilmington Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 at M

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Obesity

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 8/20/48

G66056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G66056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 South Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH COSTELLO JOSEPH ELWOOD COSTELLO

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara Fitzgerald Costello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 3, 1873

8. AGE: Years 75 | Months 5 | Days 17 16 | If less than one day hr. min.

9. Birthplace Media, Pa.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business R. W. Norris Co.

FATHER
12. Name ? Costello
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Clara L. Costello
(b) Address 1817 South Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/23/48 (month) (day) (year)
(c) Cemetery Greenmount
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) [illegible] Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8 1948 to Aug 19 1948, and that I last saw him alive on Aug 19 1948.

	Duration
Immediate cause of death: (a) Bronchopneumonia	
Due to: (b) Hypostatic	
Due to: (c) Pulmonary Edema	
Other Conditions: Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Kot M. D.
Address Sinai Hospital Date signed 8/23/48

VS 150

G66057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. G66057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use figures for dates, ages, and addresses. Write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 222 S. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Lawrence O'Bryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1883

8. AGE: Years 64 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Md. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto City

FATHER 12. Name Patrick O'Bryan

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Donovan

15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Curtis Bay Md.

18 (a) Funeral director Harry E. Nock & Sons

(b) Address Eastern Ave & Ponca St.

19 [illegible] 21 1948 Filed by Huntington Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8-19 1948, and that I last saw h[illegible] alive on 8-19 1948

Immediate cause of death Hemoglobinuria — Duration days

Hemoglobinuria

Due to

Due to

Other Conditions Acute urinary retention — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Gordon Craft M. D.

Address Balt City Hosp. Date signed 8/17/48

VS 150

G66058

G66058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 28 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town College Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7206 Dartmouth Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Ingram Oswald

3 (b) If veteran, name war: no
3 (c) Social Security Account No: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Anna E. Oswald
6 (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) July 30, 1883
8. AGE: Years 65 | Months 0 | Days 22 | If less than one day: hr. min.
9. Birthplace Cheraville, md (Town, county, and state)
10. Usual Occupation asst. Dir extension service
11. Industry or business Univ. of Maryland

FATHER
12. Name Daniel Oswald
13. Birthplace Cheraville, md.

MOTHER
14. Maiden Name Miss Ingram
15. Birthplace Maryland

16 (a) Informant Henriette Bess Oswald
(b) Address 7206 Dartmouth ave College Park Md
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 24 1948 (month) (day) (year)
(c) Cemetery or crematory Hyattsville
Location Hyattsville, Md
18 (a) Funeral director Francis Leach Sons
(b) Address Hyattsville, Md
19 (a) Date received by registrar AUG 25 1948 (b) Registrar Centington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 at 4.55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 1 1948 and that I last saw him alive on Aug 19 1948.

Immediate cause of death: Respiratory Arrest
Due to: metastatic carcinoma of right cerebellar hemisphere
Due to: Carcinoma of Lung
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: symptoms since May 1, '48; at least 4 mos

Date of operation: 1944 Biopsy of (scar) breast; May 28, 1948 exploratory laparotomy
Major findings of operation: May 28, 1948 metastatic nodules in liver
Date of autopsy:

PHYSICIAN (Underline name of physician who should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in each case)
(e) Means of injury
23. Signature J. R. Hamtramck M. D.
Address Univ. Hosp Baltimore-1, Md.
Date signed 8/21/48

Please answer all questions. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G66059
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Southern Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles K. Ditman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Rachel Ditman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1862

8. AGE: Years: Abt. 86 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation C. P. A.

11. Industry or business Self

FATHER
12. Name William H. Ditman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Henry J. Mitchell
(b) Address Southern Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director C. W. Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) (b) Registrar
(Date rec'd by registrar) AUG 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Aug. 20 1948, and that I last saw him alive on Aug. 15 1948

Immediate cause of death Intestinal malignancy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterson M. D.
Address 2324 Reisterstown Rd Date signed 8/21/48

G66060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170a

Registered No. G66060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3653 Dolfield Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL STERN (DANIEL STERN.)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christie Stern.
6 (d) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.20, 1876.

8. AGE: Years 72 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Insurance
11. Industry or business Salesman.

FATHER
12. Name Jacob Stern,
13. Birthplace Germany.

MOTHER
14. Maiden Name Yetta Diebach,
15. Birthplace Germany.

16 (a) Informant Mr. Jerome Stern,
(b) Address 3653 Dolfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto, Md.

18 (a) Funeral director Sharrer Funeral Home
(b) Address 1902 Eutaw Place, Baltimore, Md.

8/21 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948 at 11A M 28

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head with avulsion of brain, Crushed chest and pelvis

Due to

Other Conditions Other fractures, lacerated and ruptured organs with internal hemorrhage. Multiple ragged wounds, brush burns, etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/11 over

(a) Date of injury 8-20-48 at age of 9:50 A.M.
(b) Where did injury occur? Western Maryland Crossing - Lewin Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? R. R. Prop. While at work? yes
(d) Means of injury Truck and train collision

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 8-20-48

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Marlborough Apts. 14
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE STRAUSS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1882.

8. AGE: Years	Months	Days	If less than one day
66	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Retired Clothing Sales-
11. Industry or business man

FATHER
12. Name Joseph Strauss,
13. Birthplace Germany.

MOTHER
14. Maiden Name Fannie Stern,
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. N. Epstein,
(b) Address Atlantic City, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levin Funeral Home
(b) Address 1902 Eutaw Place.

8/24, 1948 (Date received by registrar) (b) Livingston Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21st. 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1948 to Aug. 21 1948. and that I last saw h Wa alive on Aug. 20 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Cardio-vascular Disease Atherosclerosis

Due to

Other Conditions Convales. Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis L Jacob M. D.
Address 1700 Eutaw Pl. Date signed Aug. 24 '48

VS 150

G66062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G66062
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 North Carey Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 East Arlington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada E. Waddy Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife John E. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22 1896

8. AGE: Years	Months	Days	If less than one day
51	11	22	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Joseph Dennis
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mamie Costella
15. Birthplace Frederick Maryland

16 (a) Informant John E. Thomas
(b) Address 911 East Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 28 1948 (month) (day) (year)
(c) Cemetery or crematory Adelphia Memorial Park
Location Baltimore City Maryland

18 (a) Funeral director Joseph A. Ryley
(b) Address 616 West Baltimore Street

19. Filed by registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1948 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Aug 18 1948 and that I last saw h[illegible] alive on Aug 18 1948.

Immediate cause of death	Duration
Pulmonary Embolism	Few days
Due to Breast Cancer	2 yrs
Due to	
Other Conditions Fatal Weakness	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 753 W. Fayette Date signed Aug 19 48

VS 150

G666063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G666063

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Holmes Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Bernard H Kaminsk

3 (b) If veteran, name war —

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			..... hr. ..... min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation none

11. Industry or business .....

FATHER
12. Name Abraham
13. Birthplace Austria

MOTHER
14. Maiden Name Hannah
15. Birthplace Austria

16 (a) Informant Dept Records
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22 1948 (month) (day) (year)
(c) Cemetery or crematory Beth Jacob
Location Wilkens Ave & Dek

18 (a) Funeral director Jack Louis Sons
(b) Address 1210 Eastern Ave

(a) 22 1948 (b) .....
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1948; at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1948, to 8-22 1948, and that I last saw h[illegible] alive on 8-22 1948.

Immediate cause of death Coronary
Manifestation of

Due to .....

Due to .....

Other Conditions Ca of Sigmoid

(Include pregnancy within 3 months of death)

Date of operation 8-9-48

Major findings of operation: Ca of Sigmoid

of autopsy .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Roger Sorrell M. D.

Address ..... Date signed 8-23-48

G66064 BALTIMORE CITY HEALTH DEPARTMENT G66064
Registered No.

CERTIFICATE OF DEATH 183a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: SINAI HOSPITAL BALTIMORE MD. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE BURGAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex ♀ F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Gilbert
13. Birthplace Austria.

MOTHER
14. Maiden Name not known
15. Birthplace Austria

16 (a) Informant Jacob Burgan
(b) Address 2815 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Woodsor Nuck Road

18 (a) Funeral director Jack Kaufer Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948 at 2 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 20 1948, and that I last saw her alive on Aug 20 1948.

Immediate cause of death Cerebrovascular accident - left.

Due to hypertension arteriosclerosis

Due to generalized arteriosclerosis

Other Conditions malnutrition ac. pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Harris /cm & Wexler M. D.
Address [illegible] Date signed 8/20/48

G666065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G666065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Dworkin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Naomi
15. Birthplace Russia

16 (a) Informant Isadore Malmow
(b) Address 2429 Linden Ave

17 (a) Burial (b) Date thereof 8-22-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2616 Eutaw Place

19 (a) 1948 (b)
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1948, to Aug 20 1948, and that I last saw him alive on Aug 20 1948.

Immediate cause of death Coronary insufficiency — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 18

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roger Hoerr M. D.
Address Sinai Hosp. Date signed Aug 20 '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 N. Payson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ray Levy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace England

16. (a) Informant Bernard Spurlock
(b) Address 1600 Eareckson Pl

17. (a) Burial (b) Date thereof Aug 22, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workmen Circle
Location Mt Carmel

18. (a) Funeral director Jewish Levine Mem
(b) Address 2108 Eutaw Pl

19 (a) 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1948, at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948, to 8-21 1948, and that I last saw h. alive on 8-21 1948.

Immediate cause of death Myocardial insufficiency — Duration

Due to Coronary sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hospital Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G66067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G66067
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Answer all questions fully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution 2813 Sunset Drive
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MdD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Sunset Drive
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lomax Walter Poole
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-098306
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 15 1884
8. AGE: Years 64 Months 1 Days 5 If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Steple Jack
11. Industry or business

FATHER
12. Name Allen J
13. Birthplace Va

MOTHER
14. Maiden Name Mary B Elliott
15. Birthplace Va

16 (a) Informant Wife
(b) Address 2813 Sunset Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Richlin Hgts

18 (a) Funeral director Edward Foulkrod
(b) Address 2359 Wash Blvd

AUG 22 1948 (Date received by registrar) (Signature of Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Aug. 1948 at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June, 1946 to Aug 1948. and that I last saw him alive on 20 Aug 1948.

Immediate cause of death Coronary Artery Occlusion — Duration 2 yrs.

Due to Severe Arteriosclerosis

Due to

Other Conditions Carcinoma, gastric — 8 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Bayless M. D.
Address 1000 Wilkens Ave Date signed 21 Aug 48

gda

G66068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66068
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution:
Franklin Sq Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Snow Hill Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Love

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race Colored | 6 (a) Single, ~~Married~~ Widowed, or Divorced. Married

6 (b) Name of husband or wife Mehlbii

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 1908

8. AGE: Years 39 40 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Richard Allen
13. Birthplace Md.

MOTHER 14. Maiden Name Lillian Hawkins
15. Birthplace Md.

16 (a) Informant Husband
(b) Address Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County Md.

18 (a) Funeral director Mc Roff & Elliott Dept
(b) Address 1129 N Caroline St

AUG 2 1948 (b) (Date received by registrar) Registrar

Courtesy of Maryland State Archives

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948 at 2 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948, to 8-19 1948, and that I last saw her alive on 8-19 1948

Immediate cause of death	Duration
Cerebral hemorrhage	10 hr.
Due to Hypertensive C.V. disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hospital Date signed 8-19-48

G66069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G66069
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information must be answered, or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chaplegate Lane
(c) Hospital or institution: Pine Crest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 600 S Chaplegate Lane (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Georgeanna Cole
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife J Best Cole
(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) June 13 - 1870
8. AGE: Years 78 Months 2 Days 8 If less than one day hr. min
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name J Howard Kemp
13. Birthplace Md

MOTHER
14. Maiden Name Susan Annacent
15. Birthplace Md

16 (a) Informant: J Best Cole
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 24/48 (month) (day) (year)
(c) Cemetery or crematory Grace Methodist
Location Baltimore Md

18 (a) Funeral director Edw A Piper
(b) Address Hampstead Md

19 (a) 1948 (Date) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 at 9.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to August 21 1948, and that I last saw her alive on August 21 1948.

Immediate cause of death Senility — Duration 10 yrs

Due to

Due to

Other Conditions Senile dementia 2 yrs
hypertension
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 8/22/48

VS 250

162a

G66070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G66070

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Fawn. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 907 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Valenti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Josephine Masumeci

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1882

8. AGE: Years 66 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Rosario Valenti
13. Birthplace Italy

MOTHER
14. Maiden Name Ignazia ?
15 Birthplace Italy

16 (a) Informant Charles Valenti (Son)
(b) Address 907 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Moravia Ave.

18 (a) Funeral director Frank Pellegrini
(b) Address 322 S. High St.

AUG 22 1948
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19 48 at 1 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 10 19 48 to Aug 20 19 48
and that I last saw h alive on Aug 20 19 48

Immediate cause of death Ruptured
aneurysm of Brain.

Due to Hypertension &
Arteriosclerosis -

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature
Address Signature signed Aug 21 48

correct age is especially important. Physicians: please write the cause of death clearly.

VS 190

G66071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. G66071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Madison Aves.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. ~~(yrs., mos.,~~ or days) 2
(e) Length of stay in Baltimore ~~(yrs., mos.~~ or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Hall (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 34 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Canova.

3 (b) If veteran, name war none

3 (c) Social Security Account No. 216-07-5733

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Ethel Jane Canova
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 17, 1904

8. AGE: Years	Months	Days	If less than one day
43	10	6	— hr. — min.

9. Birthplace Philadelphia, Penna. (Town, county, and state)
10. Usual Occupation Skilled Laborer
11. Industry or business Private Contractor

FATHER
12. Name Anthony Canova
13. Birthplace Naples, Italy

MOTHER
14. Maiden Name Christina Poggi
15. Birthplace Naples, Italy

16 (a) Informant Ethel Jane Canova.
(b) Address White Hall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Texas, Balto. Co., Md.

18 (a) Funeral director Jacob Hartenstein
(b) Address Peter Freedom, Pa.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1948, at 1.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 8-23 1948, and that I last saw him alive on 8-23 1948

Immediate cause of death	Duration
Cardio-Pulmonary Failure	
Due to Shock, Hemorrhagic, acute	
Due to Gastric Ulcer	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death.)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Brunden M. D.
Address Md. Gen. Hosp. Date signed 8-23-48

PLEASE WRITE PLAINLY, WITH INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

G66072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G66072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Schapiro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1915

8. AGE: Years	Months	Days	If less than one day
33	6	5	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Jacob Mopsikov
13. Birthplace Russia

MOTHER
14. Maiden Name Birdie Lavenstein
15. Birthplace Russia

16 (a) Informant Abraham Schapiro
(b) Address 3820 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Mickro Kodesh
Location Bowleys Lane, Herring Run

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Ave

19 AUG 23 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Aug 22 1948 and that I last saw h alive on Aug 22 1948

Immediate cause of death Cardio-respiratory - renal failure

Due to Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan A. Marks M. D.
Address Sinai Hosp Date signed 8/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C66073

3C - 48-16715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

C66073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 IRVINE PLACE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREA PARSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	WHITE	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-21-48

8. AGE— Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name Leon Parsley
13. Birthplace W. Va.

MOTHER
14. Maiden Name JUNE EASTHAM
15. Birthplace KENTUCKY

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation~~, removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 21 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 8-21 1948, and that I last saw her alive on 8-21 1948.

Immediate cause of death: Pneumonia

Due to: Acute Infantile Diarrhea

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type if fatal)
(e) Means of injury

23. Signature Milton Markwell MD M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G66074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G66074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. Accurate and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3750 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NETTIE C. BARTHOLOMEW

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1880

8. AGE: Years	Months	Days	If less than one day
67	10	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Frank L. Colling
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Hobbs
15. Birthplace Maryland

16 (a) Informant Mrs. Nathe Turner
(b) Address 3750 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1948, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 8-22 1948.
and that I last saw h.[illegible] alive on 8-21 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions Secondary Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Everhart M.D.
Address 36 York Ct. Date signed 8/22/48

66075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where applicable. Do not leave blanks. Be sure to give correct age in years, months, days, hours, or minutes. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3523 Lucile Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Lucile Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred L Petersen

3 (b) If veteran, name war No
3 (c) Social Security Account No. 215-01-4817

4. Sex Mal
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Christina
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 24 1883
8. AGE: Years 64 Months 7 Days 27 If less than one day hr. min.
9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Empire Coal Co

FATHER
12. Name Martin Petersen
13. Birthplace Denmark

MOTHER
14. Maiden Name Christine Mathiesen
15. Birthplace Denmark

16 (a) Informant Gustav Petersen
(b) Address Randallstown Md
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8-24-48 (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Catonsville Md
18 (a) Funeral director Tilhum & Son Inc
(b) Address 1340 E Fayette St
19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 6:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948 to Aug 21 1948, and that I last saw him alive on Aug 21 1948.

Immediate cause of death Carcinoma of Lung — Duration 5 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Manuel Lewis M. D.
Address 3818 Reisterstown Rd Date signed Aug 24 48

V S 150

666076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 666076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct as far as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3202 Overland Ave

(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3202 Overland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** George J. Blomeier.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Blomeier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 10th 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	6	10		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Coal & Oil Merchant.

11. Industry or business Retired

FATHER 12. Name Ernest Blomeier.

13. Birthplace Germany

MOTHER 14. Maiden Name Friederich Hille

15. Birthplace Germany

16 (a) Informant Mrs Minnie Blomeier

(b) Address 3202 Overland Ave

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Aug 23 (month) (day) (year)

(c) Cemetery or crematory Lorraine Mausoleum

Location Burial

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20th 1948 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to Aug 20 1948, and that I last saw him alive on Aug 20 1948.

Immediate cause of death Chronic myocarditis — Duration 20 yr

Due to Severe arteriosclerosis

Due to Hypertension

Other Conditions Dry gangrene feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. V. Harbold M.D. M.D.

Address 4706 Harford Road Date signed 8/24/48

VS 150

66077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 66077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2636 Frederick ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 +
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Frederick ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Pitzinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-9245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Bessie L. Pitzinger
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) Aug 18, 1884

8. AGE: Years	Months	Days	If less than one day
64	0	3	hr. min.

9. Birthplace Talbridge Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John W. Pitzinger
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Margaret Dewald
15 Birthplace Maryland

16 (a) Informant Mrs Bessie L. Pitzinger
(b) Address 2636 Frederick ave Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1948 (month) (day) (year)
(c) Cemetery or crematory Melville Cemetery
Location Talbridge Md.

18 (a) Funeral director D. Lester Earle
(b) Address 5503 Main St. Elkridge, Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) Evelyn for William [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1948 to Aug 21 1948 and that I last saw h[illegible] alive on Aug 21 1948

Immediate cause of death Stomach Carcinoma

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert H. Yates
Address 2032 Walbrook Ave Date signed 8/24/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Omission of information or incorrect age is especially important.

VS 150

G66078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66078

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give full name of street address or location; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5404 Purlington Way
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr. 3[illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5404 Purlington Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Mary Elizabeth Kinney

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband/wife ##### Michael H. Kinney
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 75	---	---	--- hr. --- min.

9. Birthplace Girard, Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Edward H. O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Kelly
15. Birthplace Ireland

16 (a) Informant Mrs. Norene K. Lewis
(b) Address 5404 Purlington Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1948 to 8/22 1948 and that I last saw him alive on 8/22 1948

Immediate cause of death: Cerebral apoplexy — Duration

Due to: Hypertension and arterio-sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Reed M.D.
Address 240 N Purlington Date signed 8/24/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital - Balto Md. (Or Location) Memorial Hospital
(d) Length of stay in Hospital or Inst. (yrs., mos., or days) 1 yr 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Patricks Church (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ireland

3 (a) FULL NAME: Rt. Rev. James I. Quinn, V. F.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 11, 1875
8. AGE: Years 72 Months 9 Days If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Priest
11. Industry or business

INFORMANT
12. Name William F. Quinn
Address Ireland
14. Maiden Name Catherine Kelly
15. Birthplace Ireland
16 (a) Informant: Rev. Chas. B. Bergen Rect. St. Patrick St. Cumberland Md.
(b) Date thereof 8/25/48 (month) (day) (year)

(c) Cause of death
Location Cumberland, Md.
13 (a) Funeral director E. H. Mead & Son
(b) Address 805 N. Calvert St.
19 AUG 23 1948 (Date rec'd by registrar) (b) Huntington Maryland Registrar

VS 150 Via Automobile Hearse

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 at 5:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 19 47 to 8/20 19 48 and that I last saw h[im] alive on 8/20 19 48.
Immediate cause of death Cardiac failure
Interarterial CV
Due to Disease of
Due to Diabetes chronic decompensation
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Venable for MD M. D.
Address St Agnes Hospital Date signed 8/24/48

PLEASE WRITE IN INK WITH UNFADING INK. Every item of information should be carefully supplied. Every item is important. Physicians: please write the cause of death clearly and legibly.

G66080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lutheran Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town 168 W. Cross (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT 12092 COSTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 3. 1903

8. AGE: Years	Months	Days	If less than one day
44	8	17	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER	12. Name	Horace Coston
	13. Birthplace	Va
MOTHER	14. Maiden Name	Annie Ross
	15. Birthplace	md

16 (a) Informant Annie Coston
(b) Address 1814 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 43 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stagg
(b) Address 142 W. Fayette St

19. AUG 23 1943 (Date Accepted by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1943, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1943, to 8-20 1943, and that I last saw h alive on 8-20 1943.

Immediate cause of death	Duration
(a) Pulmonary edema INTRA	
Due to (b) Intracerebral hemorrhage - left	
Due to (c) Hypertensive cardio vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-24-43

Major findings of operation: Intracerebral hemorrhage - left

If autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signeture W. Edward Goldsborough M. D.
Address Lutheran Hosp Date signed 8-21-43

X

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as far as possible. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 N Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George N Hildmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1873

8. AGE: Years 75 | Months | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Hildmann

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lydia Scheit

15. Birthplace Baltimore Md

16 (a) Informant Mrs Mary E Flock

(b) Address 2723 Englewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)

(c) Cemetery or crematory Loraine

Location Balto. Co. Md.

18 (a) Funeral director Wilson Co Inc

(b) Address 1517 E Fort Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1948 to Aug 20 1948 and that I last saw h— alive on Aug 20 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to Hypertension — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Shipsman M. D.

Address 753 N Patterson Park Ave Date signed Aug 23 1948

V S 150

66082

HEALTH DEPARTMENT—~~CITY OF~~ BALTIMORE 66082

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH
~~CITY OF BALTIMORE~~: (No. 309 E 22ND ST. St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME ARTHUR MITCHELL MORROW

(a) Residence: No. 309 E 22ND St., 12-4 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) SEPT 9, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	11	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. MACHINIST

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) ANDERSONBURG
(State or country) PENNSYLVANIA

FATHER

13. NAME RICHARD MORROW

14. BIRTHPLACE (city or town) PENNSYLVANIA
(State or country)

MOTHER

15. MAIDEN NAME SARA HOHENSHILT

16. BIRTHPLACE (city or town) PENNSYLVANIA
(State or country)

17. INFORMANT MRS VYRTA HATFIELD
(Address) 309 E 22ND ST

18. BURIAL, CREMATION, OR REMOVAL
Place MEADOWRIDGE Date AUG 24 1948

19. UNDERTAKER INM Cook INC
(Address) 1217 ST PAUL ST. Huntington Valley, Md.

20. FILED AUG 23 1948 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 22, 1948

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1948, to Aug 22, 1948
I last saw alive on Aug 21, 1948. Death is said to have occurred on the date stated above, at 4 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	7/1948
Paralysis	
Arteriosclerosis	10 yrs
Anorexia	2 days

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ✓ Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Chas. A. Zimmerman M. D.

(Address) 2458 Harford Rd

X

state CAUSE OF DEATH in this space, in terms of disease and modes of violence. OCCUPATION is very important. See instructions on back of certificate.

666083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Use figures for dates and ages. If unknown, write "unknown." Do not abbreviate. Give full name of city or town. Be sure to give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stone

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4 Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced** Married

6 (b) Name of husband or wife Dora Weinman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1885

8. AGE: Years 63 | Months 3 | Days 23 | If less than one day: hr. min. 2

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Henry M. Stone
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah B. Cobrinsky
15. Birthplace Russia

16 (a) Informant Mrs. Dora Stone
(b) Address 2230 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Har Zion Cem
Location Randall

18 (a) Funeral director Sol Gelman & Bro
(b) Address 1124-26 W North Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) **(b)** Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22, 1948 to Aug 23, 1948, and that I last saw h alive on Aug 23, 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Uremia	
Due to Arteriosclerosis	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Date of autopsy not yet reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Sinai Hosp. Date signed 8-23-48 M. D.

VS 150

1318

G66084
AB-122114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66084
Registered No.

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Holly Neck Grill-RFD #3 Box 336 B
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Logan Bernard -or George Logan Barnard

3 (b) If veteran, name war

3 (c) Social Security Account No. 315-14-0220

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1-1902 May 31-1903-or

8. AGE: Years 45? or Months 3 Days 19 If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name George Bernard
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ruth Hitchock
15. Birthplace Kentucky

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-24-48 (month) (day) (year)

(c) Cemetery or crematory
Location Emmorville Md

18 (a) Funeral director J J Burgunder
(b) Address 1407 Eastern Ave Rd Baltimore, Md

19 (a) AUG 23 1948 (Received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20- 1948 at 6.40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-14 1948 to 8-20 1948 and that I last saw him alive on 8-20 1948

Immediate cause of death: Sub-dural Hematoma, acute, r t side
Due to: trauma
Due to:
Other Conditions: Bronchopneumonia, Pulmonary edema.
(Include pregnancy within 3 months of death)
Date of operation 8-14-48
Major findings of operation: Sub-dural Hematoma
of autopsy: Same

Duration: 2 hrs? 1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Unknown Acc?
(b) Date of occurrence 8-14-48? at 10 AM
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from ladder

23. Signature [illegible]
Address 4940 Eastern Ave Date signed 8-21-48 M. D.

CERTIFICATE TO BE APPROVED BY THE MEDICAL EXAMINER
Dr. H. T. B. McFadden, per Thomas J. Mackin m.d.

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Jonquil ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Jonquil ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Wiener

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-8-97

8. AGE: Years 51 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Dvora
15. Birthplace Russia

16 (a) Informant Lena Wiener
(b) Address 556 Jonquil ave

17 (a) Disposition (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Kaven, Inc.
(b) Address 2160 Eutaw Place

19 AUG 23 1948 (b) (Registrar) Counting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22-1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 8/22 1948, and that I last saw him alive on 8/22 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to

Due to

Other Conditions Coronary Artery Dis — 17 mo

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund A. Mallis, M.D.
Address 1847 W. North Ave Date signed 8/23/48

VS 150

X

86086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 86086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3500 DENNLYN RD

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3500 DENNLYN RD

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ALBERT LIBOWITZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1879

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation MERCHANT

11. Industry or business

FATHER 12. Name NATHAN LIBOWITZ

13. Birthplace RUSSIA

MOTHER 14. Maiden Name ROSE

15. Birthplace RUSSIA

16 (a) Informant WIFE

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)

(c) Cemetery or crematory BALTO HEBREW

Location BELAIR RD

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100 EUTAW PLACE

19 (a) AUG 23 1948 (Date rec'd by registrar) Remington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 22 1948 at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939 to Aug. 22 1948 and that I last saw him alive on Aug. 20 1948

Immediate cause of death Arteriosclerotic Cardio-vascular Disease with Hypertension — Duration 10 years

Due to

Due to

Other Conditions Uremia — 6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. A. Trooman M. D.

Address 1109 N. Calvert St Date signed 8/23/48

VS 150

66087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

Registered No. 66087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill all blanks. Give correct age in years. Physicians: please write the causes of death clearly and legibly. Information is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution:

Sinai 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits write RURAL and give town)

2

(d) Street No. 1737 E. Balto St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Rivlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Not Known

13. Birthplace Russia

MOTHER

14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Charles Rivlin

(b) Address 1737 E Balto St

17 (a) Burial (b) Date thereof 8-23-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lemer Inc

(b) Address 200 Eutaw Place

19 (a) [illegible] (b) Washington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22, 1948 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15, 1948 to AUG 22, 1948 and that I last saw HIM alive on AUG 22, 1948.

Duration

Immediate cause of death Cardio-respiratory failure

Due to Uremia

Due to Poss neplasm urinary tract neoplasm

Other Conditions Poss CA pulmonary & liver metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Irma M. Cushner, M.D.

Address Sinai Hospital Date signed 8-22-48

VS 180

131a

66088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66088

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 FOSTER AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 FOSTER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J. TRAGER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ELIZABETH TRAGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 11, 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	2	9		

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name ? TRAGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN.
15. Birthplace GERMANY.

16 (a) Informant CHARLES J. TRAGER JR.
(b) Address 3602 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-23-48. (month) (day) (year)
(c) Cemetery or crematory 1ST UN. EVANGELICAL
Location O'DONNELL ST.

18 (a) Funeral director Charles J. Zeiler
(b) Address 901 S. CONKLING ST.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20, 1948 at 4 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Aug 20 1948
and that I last saw him alive on Aug 20 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 mos.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Gaudal M. D.
Address 630 S. Conkling St. Date signed 8-21-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. C66089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Print correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 15+2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs and 40 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1717 N. Read Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

2 (c) FULL NAME William Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hattie Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1897

8. AGE: Years 50 | Months 8 | Days 9 11 | If less than one day hr. min.

9. Birthplace Bark River, Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name William Smith Sr.
13. Birthplace Barkriver, Md.

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant Wife / hospital record
(b) Address None

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1948 (month, day, year)
(c) Cemetery or crematory Lincoln Park
Location Capitol Hts. Md.

18 (a) Funeral director Wm. Lawrence A. Stuller
(b) Address 1632 Druid Hill Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1948 at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 8-21 1948, and that I last saw him alive on 8-21 1948.

	Duration
Immediate cause of death: Pulmonary Edema 12 hrs	12 hrs
Due to: Cardiac decompensation	48 hrs
Due to:	
Other Conditions: Diabetes mellitus - duration - unknown (Include pregnancy within 3 months of death)	unknown

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joana D. Carr M. D.
Address 515 Marlboro St Date signed 8-24-48

VS 190

95c

66090 Bal 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G66090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Ethering St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thornton Gillis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Clementine
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 6-12-88

8. AGE: Years	Months	Days	If less than one day hr.	min.
60	2	8		

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER 12. Name Henry Gillis
13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Matthews
15. Birthplace Virginia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Holland
(b) Address 1625 Druid Hill Ave.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Buried Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948 at 7:25 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1948 to 8-20 1948.
and that I last saw him alive on 8-20 1948.

Immediate cause of death Carcinoma of Lung — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Carcinoma of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/20/48

correct age is especially important. Physicians, please write plainly.

6091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Accuracy in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Provident Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2030 Pulaski Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ruth Garnes (GARNES)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clyde

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1898

8. AGE: Years 50 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Parks

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Mary Simpson

15. Birthplace Balt Co. Md.

16 (a) Informant Mrs. Clyde Garnes

(b) Address 2030 Pulaski Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Cooper & Sons

(b) Address 1600 Druid Hill Ave.

19 (a) AUG 23 1948 (Date rec'd by Local Reg.) (b) Signature of Local Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948, at 7:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/20 1948 and that I last saw h alive on 8/20 1948.

	Duration
Immediate cause of death: Uremia	
Due to: Hypertension C V Renal Disease	4 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Preston Stuart M.D.

Address 640 N. Gracelton Date signed 8/21/48

66092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 23st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Rudolph Broring

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 215-05-0907

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jun 21, 1886

8. AGE: Years 62 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Bernard H. Broring
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Taylor
15 Birthplace Germany

16 (a) Informant Records
(b) Address U.S. Marine Hosp., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md.

18 (a) Funeral director C. J. Dempsey & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Contagion Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 19 48 to Aug 21 19 48. and that I last saw him alive on Aug 21 19 48.

Immediate cause of death: Thrombosis, basilar artery — Duration: 1 day

Due to: Arteriosclerosis, gen. — Duration: unknown

Due to: Hypertensive cardiovascular disease — Duration: 8 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Robert S. Miller M. D.
Address US Marine Hosp. Date signed 8/21/48

VS 150

correct age is especially important

666093 TIGNALL ✓ G66093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 1a
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret T. Tignall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Tignall

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Sept. 20, 1881

8. AGE: Years 66 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and State)

10. Usual Occupation House wife

11. Industry or business at Home

FATHER 12. Name Edward Griffin

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McEnaney

15. Birthplace Ireland.

16 (a) Informant Mrs Charles J. Tignall

(b) Address 1602 Rosedale St.

17 (a) buriel (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Bowen Son

(b) Address 901-03 W. Collins st.

19 AUG 23 1948 (Date rec'd by registrar) Huntington Millspaugh M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1948, at 3 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948, to 8-20 1948, and that I last saw her alive on 8-20 1948

Immediate cause of death: Cardio Respiratory failure — Duration: [illegible]

Due to: Coronary Thrombosis — Duration: 1 wk.

Due to:

Other Conditions Diabetes Mellitus Dehydration Uremia, terminal circumstances

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary Sclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Joseph LiPuma M.D.

Address Mercy Date signed 8/20/48

9.4a

correct age is especially important. Physicians: please write the cause of death plainly.

VS 190

G66094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Pinewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Pinewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODATE FRANCIS

3 (b) If veteran, name war no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Marion A. Francis
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 18. 1878

8. AGE: Years	Months	Days	If less than one day
70	0	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward A. Knott
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Towson
15. Birthplace Maryland

16 (a) Informant Mr. Marion A. Francis Sr.
(b) Address 3023 Pinewood Ave. - 14

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Aug. 24. 194 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) **(b)** Interment [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that age is correctly stated. Underline the cause to which death should be charged statistically.

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21. 1948 at 12.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to Aug. 21, 1948. and that I last saw her alive on Aug 20, 1948.

Immediate cause of death Coronary Thrombosis — **Duration**
Due to Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Wolfe M. D.
Address 1331 E. Monument Ave Date signed 8-21-48

66095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G66095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3240 E. Lombard St., Balto.-24
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

✓

3 (a) FULL NAME Mrs. Lina Resch

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	white	married

6 (b) Name of husband or wife: George M. Resch Sr.
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.): January 30, 1868

8. AGE: Years	Months	Days	If less than one day
80	6	20	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Wife
11. Industry or business: Home

FATHER
12. Name: George M. Rohrig
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Margaret Morris
15. Birthplace: Baltimore Md

16 (a) Informant: Mr. Frederick H. Resch (Son)
(b) Address: 2930 Edison Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: Baltimore Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Station, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-48 19 . at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/ 19 48 to 8/20/ 19 48.
and that I last saw her alive on 8/20/ 19 48.

Immediate cause of death: Broncho - Pneumonia — Duration

Due to: Arterio-sclerotic Heart Disease

Due to: Hypostatic Congestion

Other Conditions: Myocardial Insufficiency

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury:

23. Signature: Ray E. Parsons Jr. M.D.
Address: St. Joseph's Hosp. Date signed: 8/20/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

66096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G66096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Last name of deceased should be underlined. Be sure to give correct age in years. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Rosalie Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (14)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Rosalie Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Edwin T. Burke

3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-05-3459

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola Burke (nee Bosley)
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 2 1894

8. AGE: Years 54 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business B. & O. R.R.

FATHER
12. Name John Burke
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Fate (?)
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Viola Burke (Wife)
(b) Address 2808 Rosalie Ave. Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem. Park
Location Parkville, Md.

18 (a) Funeral director C. Bowland Ferm
(b) Address 1400 St. Paul St. Balto. 2, Md.

AUG 23 1948 (Date received) (b) Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Fri., Aug. 20, 1948 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 20 1948 and that I last saw him alive on July 19 1948 (8/19/48)

Immediate cause of death Myocardial Insufficiency. — Duration —

Due to —

Due to —

Other Conditions Mitral Regurgitation Hypertension
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature John C. Schenuit M.D.
Address 1337 Schroeder St. Date signed 8/21/48

VS 150

G66097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66097

83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 522 S Caroline St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 522 S Caroline St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 27 1891

8. AGE: Years	Months	Days	If less than one day
57	4	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domesitc

11. Industry or business

FATHER

12. Name Edward Taylor

13. Birthplace Virginia

MOTHER

14. Maiden Name Annie Banks

15. Birthplace Dorchester Co. Md.

16 (a) Informant Margret Johnson

(b) Address 522 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 23. 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery. Cem.

Location Brookly Md.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly

19 (a) (Date rec'd by registrar) AUG 23 1948 Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1948, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to Aug. 20 1948 and that I last saw her alive on Aug 20 1948.

Immediate cause of death Pulmonary edema
Cardiac failure
Due to Arteriosclerosis

Duration 2 days 1 day 10 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm L. Berry M. D.

Address 1420 E. Chase Date signed Aug 22. 48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

G66098

IB 121682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

98

Registered No. G66098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Mo.9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Maasch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Margaret A. Sparr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1879

8. AGE: Years	Months	Days	If less than one day
68	9	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernest Marsh
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Young
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) AUG 23 1948 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 19 48 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 19 48 to 8-21 19 48 and that I last saw him alive on 8-21 19 48

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions Arteriosclerosis Gangrene of Rt. Leg (Include pregnancy within three months of death)

Date of operation 8/19/48

Major findings of operation: Gangrene of Rt. Leg

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft
Address Balt. City Hosp. Date signed 8/21/48 M.D.

VS 150

107

correct age is especially important. Physicians: please write the cause of death

G66099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

✓ G66099 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 EDMONDSON AV., #23 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT BRYAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: RACHEL BRYAN
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr): APRIL 6, 1873
8. AGE: Years 75 | Months 4 | Days 15 | If less than one day: hr. min.
9. Birthplace: MARYLAND (Town, county, and state)
10. Usual Occupation: COOK
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace

16 (a) Informant: RACHEL BRYAN
(b) Address: 1527 EDMONDSON AV. #23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Antietam
Location: Baltimore

18 (a) Funeral director: Wm. A. Jackson
(b) Address: 916 Penna Ave

19 (a) AUG 23 1948 (Date received by Registrar) (b) Huntington for Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 21, 1948, at 12.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 18, 1948. to AUG. 21, 1948. and that I last saw him alive on AUG. 21, 1948

Immediate cause of death: CARDIAC FAILURE; INTESTINAL OBSTRUCTION — Duration: UNDETERMINED 6 HRS.
Due to: INCISIONAL AND INGUINAL HERNIAS — Duration: 3 YRS.
Due to: — Duration: UNDETERMINED PROBABLY CONGENITAL
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation: NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. Samuel A. Harris, M.D.
Address: 1 Med. Chir. Hosp. Date signed: 8/21/48

X

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I certify that the above is a true and correct statement of the facts relating to the cause of death. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

66100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Wilmer Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17+2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 1122 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA DELOWITCH) ELiza Delbridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Jackson, North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Miles Sykes
13. Birthplace North Carolina

MOTHER 14. Maiden Name Cherry Ann ?
15. Birthplace North Carolina

16 (a) Informant David Delbridge
(b) Address 1122 Wilmer Court

17 (a) Slipped (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Fork.
Location Weldon, N. C.

18 (a) Funeral director Williams A. Jackson
(b) Address 916 Penna. Ave.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington, West Virginia, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/48 19 , at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Wears M.D.
Medical Examiner.
Date signed 8/22/48

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Please write plainly. Physicians: please write the cause of death correctly, and fill every item correct age is especially important.

G66101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30D

Registered No. G66101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR BOWIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-17-1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	8	3		

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Bowie
13. Birthplace Md.

MOTHER
14. Maiden Name Rhoda Scott
15. Birthplace Md.

16 (a) Informant Rhoda Bowie
(b) Address 540 - W. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cemetery.
Location

18 (a) Funeral director A. Halstead
(b) Address 916 E. Lanvale St

19 (a) AUG 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948, at 11.10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured aortic aneurism, syphilitic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed August 21, 1948

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Cause of death which may give rise to claims for compensation, or which may be the result of violence, need not be stated, but the fact that violence is suspected must be stated. Do not report "Heart failure," "Asthenia," "Old age," or "Senility" without assigning the primary cause. Please report cause of death as directly as possible, avoiding terms which merely express mode of dying, such as "Shock," "Hemorrhage," "Exhaustion," "Convulsions," "Uremia," "Coma," etc. Do not use abbreviations. Do not report more than one cause on a line. Underlying causes may be stated on lines provided. Indefinite and unsatisfactory causes of death will be returned for more complete information. Please report the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

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6102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G66102

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins Avenue

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Glen Haven Pasadena, Md. R.F.D.
(If outside city or town limits, write RURAL and give town)

(d) Street No. West Shore Road
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married.

6 (b) Name of husband or wife Lloyd Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/4/1895

8. AGE: Years	Months	Days	If less than one day
53	0	16	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business OWN HOME.

FATHER
12. Name UNKNOWN - BURNS

13. Birthplace UNKNOWN.

MOTHER
14. Maiden Name UNKNOWN.

15. Birthplace UNKNOWN.

16 (a) Informant Mr. LLOYD SMITH.

(b) Address WEST SHORE Rd. Glen Haven Pasadena Md.

17 (a) BURIAL (b) Date thereof Aug. 24, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory GLEN HAVEN

Location GLEN BURNIE, Md

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie Md.

19. 8 23 1948 Thomas W. Williams, Jr. Registrar
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948, at 11:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1948 to 8/20 1948, and that I last saw h[illegible] alive on 8/20 1948.

Immediate cause of death Cardiac failure -

Due to Severe shock

Due to Massive gastro-intestinal hemorrhage - cholecystitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
..

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. J. Veatch Jr. M.D.

Address St Agnes Hospital Date signed 8/24/48

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly, as

66103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Registered No. 66103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 Cumberland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Cumberland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Eliza
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) Nov. 1, 1856

8. AGE: Years	Months	Days	If less than one day
91 92	9	20	hr. min.

9. Birthplace St. Mary's County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Eliza Butler
(b) Address 722 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh Street

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams Reg. Sec'y

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1948 to Aug 21 1948 and that I last saw h alive on Aug 21 1948

Immediate cause of death Cardio Vascular Disease — Duration 2 yrs

Due to Workmen's Compensation — Duration 3 mo's

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey
Address 1928 Penna Ave Date signed 8/23/48

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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66104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

66104 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Louise Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Heinbuch, George F. Heinbuch

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-0565

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	married

6 (b) Name of husband or wife Regina I. Heinbuch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1. 1888

8. AGE: Years	Months	Days	If less than one day
59	10	20	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None Printer
11. Industry or business —

FATHER 12. Name John Heinbuch
13. Birthplace Md

MOTHER 14. Maiden Name Denah Direhner
15. Birthplace Md

16 (a) Informant Mrs. Regina I. Heinbuch
(b) Address 2908 Louise ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern ave

18 (a) Funeral director Harry N. Bligh Jr.
(b) Address 6803 Harford Road

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/21 1948 and that I last saw h[illegible] alive on 8/21 1948.

Immediate cause of death Uremia — Duration

Due to Obstruction & Generalized Metastasis

Due to Cancer of the Bladder.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Cancer of Bladder

Major findings of operation: Sept 8, 1947

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael R. Rawards M. D.
Address 7 Kelly Hosp Date signed 3:30 AM

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

66105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Parksley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Otto Kniepert

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-09-0511

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margarete Kniepert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1883

8. AGE: Years 64 | Months 11 | Days 4 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: U. S. Lithograph Co.

FATHER
12. Name: Fritz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Maria Busse
15. Birthplace: Germany

16 (a) Informant: Mrs. Margarete Kniepert
(b) Address: 407 Parksley Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Ft. Lincoln Cem.
Location: Wash., D. C.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Lurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Aug 1948 at 6:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Edema

Due to: Cerebral Concussion

Other Conditions: Generalized Arteriosclerosis - Fresh Ankle Fracture
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 15 Aug '48
(b) Where did injury occur? Richmond-Lombard
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work?) No
(d) Means of injury Struck by auto

23. Signature: Earl L. Koons M.D. Medical Examiner.
Date signed 22 Aug 48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

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G66106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G66106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3609 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Grant Kettlewood

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ella H. Kettlewood

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1871

8. AGE: Years 76 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace: Glascow, Delaware (Town, county, and state)

10. Usual Occupation: Office Mgr.

11. Industry or business:

FATHER
12. Name: James Kettlewood
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Mary Jane Martin
15. Birthplace: Delaware

16 (a) Informant: Mrs. Ella H. Kettlewood
(b) Address: 3609 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cems.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 AUG 22 1948 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 1045 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 7, 1948, to Aug. 21 1948, and that I last saw him alive on Aug. 20 1948.

Immediate cause of death: Myocardial Failure — Duration

Due to: Cardiac Asthma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 Medical Arts Bldg. Date signed 8/23/48

Washington Williams, M.D. Registrar

66107
AB-122264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 66107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1007 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Clara Prendergast

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Donald Prendergast

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4-1907

8. AGE: Years: 41 | Months: 2 | Days: 8 17 | If less than one day: hr. min.

9. Birthplace: Md. (Rising Sun)
(Town, county, and state)

10. Usual Occupation: Waitress

11. Industry or business: Waffle Inn

FATHER
12. Name: Simeon Alexander
13. Birthplace: Md. (Rising Sun)

MOTHER
14. Maiden Name: Minnie Krouse
15. Birthplace: Md. (Rising Sun)

16 (a) Informant: Baltimore City Hospitals-record
(b) Address: 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 23 1948 (Date rec'd by reg. or dep.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22- 1948, at 11.25 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-20- 1948 to 8-22- 1948, and that I last saw her alive on 8-22- 1948

Immediate cause of death: Carcinomatosis — Duration: mos

Due to: Ca of colon — yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: 3 yrs ago

Major findings of operation: Ca of colon

of autopsy:

PHYSICIAN
Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Gordon Craft, M. D.

Address: Balt City Hosp Date signed: 8/22/48

VS 50

66108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓ Registered No. 66108

PLEASE WRITE PLAINLY, WITH PENCIL OR PEN. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Aged Home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Pollock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER'S MAIDEN NAME
12. Name Mrs. Pollock,
13. Birthplace Germany.

FATHER
14. Name Amelia Schloss,
15. Birthplace Germany.

16 (a) Informant Mrs. Lee Rascover,
(b) Address 2301 Carlton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Sons
(b) Address 2027 Eutaw Place

19 (a) AUG 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1948, at 11:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1948 to Aug. 22, 1948, and that I last saw her alive on Aug. 22, 1948.

Immediate cause of death Arteriosclerosis — Duration

Due to

Due to

Other Conditions Duodenal ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp. Date signed 8-22-48

VS 150

97

66109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 66109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Bachta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Joseph F. Bachta 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-12-1868

8. AGE: Years	Months	Days	If less than one day
80	7	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Dinberry
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Joseph F. Bachta
(b) Address 406 S. Robinson St.

17 (a) Busial (Burial, cremation, or removal) (b) Date thereof 8-1[illegible] (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt. St.

19 (a) 8-23-[illegible] (Date received by registrar) (b) [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to Aug 23 1948, and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 weeks
Due to chr. arteriosclerosis	2.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3218 Eastern Date signed 8-23-48

correct age is especially important. Physicians: please write the cause

VS 159

66110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G66110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 E Fayette St 31
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Balt 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 E Fayette St 31
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Thomas McNulty

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-9321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Julia M. McNulty
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 16 Aug 72

8. AGE: Years	Months	Days	If less than one day
No 75	-	6	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Glenburn

FATHER
12. Name Martin McNulty
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget McNulty
15. Birthplace Ireland

16 (a) Informant Mrs. Julia McNulty
(b) Address 1916 E Fayette St 31

17 (a) Burial (b) Date thereof 8-25-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 5006 E. Balt. St.

19 (a) [illegible] (b) Inventing for Williams
(Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Aug 1948 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Aug 1948 to 22 Aug 1948 and that I last saw him alive on 22 Aug 1948.

Immediate cause of death

Due to aspiration of Left-bronchus

Duration 2d.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1214 E Fayette St Date signed

PLEASE WRITE PLAINLY with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. Exact correct age is especially important.

VS 150

G66111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G66111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and the town)
(d) Street No. 2603 Goodwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur W. Byer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bessie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1894

8. AGE: Years	Months	Days	If less than one day
54	3	15	hr. min

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Steel Dye Engraver

11. Industry or business

FATHER 12. Name Henry Byer

13. Birthplace Md.

MOTHER 14. Maiden Name Sophia Nickman

15. Birthplace Md.

16 (a) Informant Mrs. Bessie Byer

(b) Address 2603 Goodwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto

18 (a) Funeral director L. J. Luck

(b) Address 5305 Stafford Rd.

19 (a) AUG 25 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Aug 1948 at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Arthur W. Byer M.D. Medical Examiner

Date signed 21 Aug 48

Please write clearly. Answer all questions correctly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 151

6112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G66112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7616 Bagley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Carville Hersch

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-9210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel M. Nichlas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 - 1898

8. AGE: Years	Months	Days	If less than one day
49	9	23	hr. min.

9. Birthplace Rock Hall Md. (Town, county, and state)
10. Usual Occupation Carpenter Supt.
11. Industry or business Edwards Corp

FATHER
12. Name John R. Hersch
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Stevens
15. Birthplace Md

16 (a) Informant Mrs Ethel M. Hersch
(b) Address 7616 Bagley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore Md

18 (a) Funeral director Leonard J. Buck
(b) Address 5205 Harford Rd.

19 (a) AUG 23 1948 (Date received by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug. 23 1948, and that I last saw him alive on Aug. 23 1948.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to Myocardial Infarction	
Due to Arteriosclerotic Coronary Artery Disease	2 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein M. D.
Address Mem Baltimore Hosp Date signed 8/23/48

correct age is especially important. Physicians: please write the causes of death clearly.

6113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-66113 46E

Registered No. 6663 3598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Bloom St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Bloom St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Mitchell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: (divorced)

6 (b) Name of husband or wife Washington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Housework

FATHER
12. Name James Wade
13. Birthplace Md

MOTHER
14. Maiden Name Ida Liggett
15. Birthplace Md

16 (a) Informant Ida Wade
(b) Address 530 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Eastman Ave

19 (a) AUG 23 1948 (Date received by Registrar) (b) Burlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20- 1948, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1948 to 8-20- 1948.
and that I last saw her alive on 8-19- 1948.

Immediate cause of death: Carcinoma of intestines — Duration: Unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:-
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 8-21-48

VS 153

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G66114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66114
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Read & Cathedral - Miller Hotel
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Read & Cathedral--Miller Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. BARNETT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13-1905

8. AGE: Years	Months	Days	If less than one day
43	-	10	hr. min.

9. Birthplace Wilmington Ohio
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Marion Barnett
13. Birthplace Ohio

MOTHER 14. Maiden Name Nellie Taylor
15. Birthplace Ohio

16 (a) Informant Roberts Funeral Home
(b) Address 921-S. Brown Street

17 (a) Removal (b) Date thereof Aug 23/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dayton
Location Ohio

18 (a) Funeral director William Cook Jr.
(b) Address 227 S. Paul Street
Huntington, W. Va.

1943 AUG 25
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1943, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of heart and acute edema of lungs

Due to

Other Conditions Chronic alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George V. Merrill M.D.
Medical Examiner.
Date signed 8-25-43

VS 151

95c

66115

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G66115

CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 451 W. 24th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON KAUFHERR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) May-14-1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31	3	9		

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Jewelry Salesman
11. Industry or business

FATHER
12. Name Maurice Kaufherr
13. Birthplace Germany

MOTHER
14. Maiden Name Thekla Heyman
15. Birthplace Germany

16 (a) Informant Mrs. Lillian Kaufherr
(b) Address 450 W. 24th St. New York

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (mo.) (day) (yr.)
(c) Cemetery or crematory
Location New York

18 (a) Funeral director John F. Connelly
(b) Address 418 Eastern Ave.

19 (a) AUG 24 1948 (Date rec'd by Registrar) (b) Burlington Wilmington

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948 at 2.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage from deep laceration of neck.
Due to Fracture of jaw.
Fracture left humerus.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-23-48 at 1.30 a. M.
(b) Where did injury occur? In front of Campbell Cement Co. Route 40 nr. Whitemarsh.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury two automobiles auto

23. Signature George G. Merrill M.D. Medical Examiner
Date signed August 23, 1948

VS 161

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Parkville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2811 Garnet Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Alfred Dorsey (Denn)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.: 215-07-7897

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gertie May Denn

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 11th, 1897

8. AGE: Years: 51 | Months: | Days: 11 | If less than one day: hr. min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Davison Chemical Co.

FATHER
12. Name: James C. Denn
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Elizabeth Chipley
15. Birthplace: Unknown

16 (a) Informant: Mrs. Alfred C. Denn
(b) Address: 2811 Garnet Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof: 8/25/48 (month) (day) (year)

(c) Cemetery or crematory: Glade Cemetery
Location: Walkersville, Md.

18 (a) Funeral director: Lanahan Funeral Home
(b) Address: 7401 Belair Rd.

19. AUG 24 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Aug 1948, at 2:33 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Earle K. Loyd M.D.
Medical Examiner.
Date signed: 22 Aug 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7543 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce M. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-6135

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Sena M. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12th, 1877

8. AGE: Years 71 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Boilermaker

11. Industry or business Spedden Ship Building

FATHER
12. Name David R. Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name Rose McCarren
15. Birthplace Pa.

16 (a) Informant Mr. Robert Smith
(b) Address 7545 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Fork Methodist
Location Fork, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7801 Belair Rd.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 10:25 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory failure

Due to: Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-23-48

correct age is especially important. Physicians: please write the cause of death

6118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G66118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132-N. Washington st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132-N. Washington st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Gilmore Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3275

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-17-1889

8. AGE: Years	Months	Days	If less than one day
58 59	8	3	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Henry Gilmore Sr

13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Harriet Jones

15. Birthplace Baltimore - Md.

16 (a) Informant Helen Roy (sister)

(b) Address 1421-E. Jefferson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-24-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore, Md.

18 (a) Funeral director Holland Funeral Home

(b) Address 1631 - Druid Hill ave.

19 AUG 24 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1948. at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 19 1948. and that I last saw him alive on 19 Aug 1948.

Immediate cause of death Respiratory aspiration

Due to Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burrell M. D.

Address 121 Argyle St Date signed 8/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 666119

correct age is especially important. Physicians: please write the cause of death plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1907 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert O. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1888

8. AGE: Years 60 | Months 2 | Days 17 | If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown Wood
13. Birthplace Unknown

MOTHER
14. Maiden Name Julie Stump
15. Birthplace Virginia

16 (a) Informant Rose F. Whyte
(b) Address 1907 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge
Location Washington Blvd.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by Registrar) AUG 24 1948

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug. 1948, at 8:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions Cerebral Vascular Accident, etc
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerd M.D.
Medical Examiner.
Date signed 23 Aug. 1948

66120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 666120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Wyndhurst Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Wyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn New Gorman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William G. Gorman, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Charles W. New
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Nettie Dinger
15. Birthplace Baltimore

16 (a) Informant Mrs. Gladys G. Grim
(b) Address 612 Wyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1800 Eutaw Place

AUG 24 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 48 at 1.10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 19 45 to Aug 19 48
and that I last saw her alive on Aug 21 19 48

Immediate cause of death Carcinoma of breast — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature William G. Gorman M. D.
Address 5006 Roland Ave. Date signed Aug 23, 48

X

Correct age is especially important. Physicians: please write the causes of death clearly and fully.

121 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 666121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Scott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac H. Tucker

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Cora V. Tucker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11. 1872

8. AGE: Years 76 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business Gas & Electric Co

FATHER
12. Name John H. Tucker
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Jones
15. Birthplace Md.

16 (a) Informant Laura D. Harris
(b) Address 614 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 (month) (day) 1948 (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John H. Tinderson
(b) Address 5311 Edmondson Ave

19 Aug 24 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1948, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to Aug 22 1948 and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death	Duration
Mitral Insufficiency	1½
Due to Generalized Arteriosclerosis	3yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 517 Scott St Date signed Aug 23/48 M. D.

PLEASE WRITE PLAINLY with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

V S 150

66122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C66122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 E. Preston.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 E. Preston. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John V. Bory.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212- 12-6858

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Bory

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 22. 1885

8. AGE: Years 62 | Months 8 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Bar Tender.

11. Industry or business Kof C. Club.

FATHER
12. Name George Bory.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Johanna Ritter.
15 Birthplace Baltimore Md.

16 (a) Informant Mrs. Minnie Bory
(b) Address 2618 E Preston. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26th 48 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Rd

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address #811 N. Wolfe. St.

19 AUG 24 1948 (Date rec'd by registrar) (c) [signature] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22nd. 1948, at 5pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 May 1948 to 22 Aug 1948.
and that I last saw h[illegible] alive on 22 Aug 1948.

Immediate cause of death: Coronary Occlusion — Duration: 3 hrs.
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1516 N. Milton Ave Date signed 24 Aug 48

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

6123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6663123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2253 Cecil Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2253 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS RUSSELL ARNOLD

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	716-12-3476	male	white	married

6 (b) Name of husband or wife Jessie L. Arnold nee Grimes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1892

8. AGE: Years	Months	Days	If less than one day
55	9	3	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Freight Conductor
11. Industry or business Penna. R. R.

FATHER
12. Name Alford Arnold
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Annie Ament
15. Birthplace Carroll Co.

16 (a) Informant Mrs. Jessie L. Arnold
(b) Address 2253 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1948 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 21 Aug 48 and that I last saw him alive on 21 Aug 48.

Immediate cause of death Uremia — Duration 11 d

Due to Polycystic kidneys

Due to Cardio-vascular disease. Abt 11 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Gaylord M. D.
Address 2925 N. Charles Date signed 23 Aug 48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

VS 30

66124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G66124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JENNIE L. DENNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles E. Dennis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1880

8. AGE: Years 68 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Rubin Hengst
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Charlett Leber
15. Birthplace: Penna.

16 (a) Informant: Mr. Howard E. Demuth
(b) Address: 4305 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) Burial Permit No. [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1948, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1948 to Aug 21 1948 and that I last saw her alive on Aug 21 1948

Immediate cause of death: Carcinoma - metastasis abdominal viscera — Duration: about 2 yrs.

Due to:

Due to primary, carcinoma of cervix — 2½ yrs.

Other Conditions Anemia — 3 mo.

(Include pregnancy within 3 months of death)

Date of operation March 1948

Major findings of operation: Carcinoma of cervix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley L. Mitchell M. D.

Address 2220 Garrison Date signed Aug 23/48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Information is especially important. Physicians: please write the causes of death clearly and legibly.

G66125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

66125

PLEASE WRITE PLAINLY, with unfading ink. Spell out full name and address. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 E. Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1728 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Jukon Ozer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-5-

8. AGE: Years 93 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER
12. Name Samuel
13. Birthplace Poland
14. Maiden Name Rachael
15. Birthplace Poland

16 (a) Informant Marsha Rosenfeld
(b) Address 1728 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Line

18 (a) Funeral director Jack Lewis Inc
(b) Address 260 Eutaw Place

AUG 24 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

19. DATE OF DEATH 8-24- 1948 at 3 05 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/18 1948 to 8/23 1948 and that I last saw him alive on 8/23 1948

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Cardiac Hypertrophy (Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Rhodes M.D.
Address 2725 Linden Ave Date signed 8/24/48

6126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 - Sterling St.
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 642 Sterling St. (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Otho Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Plaza Taylor
13. Birthplace Va. ?

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace Va.

16 (a) Informant Roosevelt Coleman
(b) Address 642 - Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 91 E. Lanvale St.

AUG 24 19[illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/48 19 , at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH, Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ivans M.D.
Medical Examiner.
Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death plainly.

G66127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G66127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 6 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. 30th St. # 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank J. Clifford

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: MARY EDNA CLIFFORD
6 (c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr)
8. AGE: Years 59 | Months 11 | Days 29 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Confectioner
11. Industry or business

FATHER
12. Name: THOMAS L CLIFFORD
13. Birthplace: ENGLAND

MOTHER
14. Maiden Name: CATHERINE WISEMAN
15. Birthplace: GERMANY

16 (a) Informant: MARY EDNA CLIFFORD
(b) Address: 335 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 26 48 (month) (day) (year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: Edmondson Ave

18 (a) Funeral director: Charles F. Evans & Son Inc
(b) Address: 118 W. Mt. Royal Ave Baltimore, Md.

AUG 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1948, at 7:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 8/23 1948, and that I last saw him alive on 8/22 1948

	Duration
Immediate cause of death: Congestive myocardial failure	1 week
Due to: Hypertensive C-V Renal Disease	? years
Due to:	
Other Conditions: Chronic fibroid apical tuberculosis, bilateral (include pregnancy within 3 months of death)	? years

Date of operation:
Major findings of operation:
of autopsy: 8/23/48 - same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Alfred H. Dann M. D.
Address: Maryland General Hosp. Date signed 8/23/48

VS 150

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

131a

G66128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G66128
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (Institution) Eutaw & Fulton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME James Spilios

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/1880

8. AGE	Years	Months	Days	If less than one day
	68	6	13	hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant (Retired)

11. Industry or business

FATHER
12. Name George
13. Birthplace [illegible] Greece

MOTHER
14. Maiden Name Thomais
15. Birthplace Greece

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Sis. of St. Agnes Our Home
(b) Address 116 N. Mt. Royal Ave.

19 (a) Date 1948 registrar [illegible] Registrar

AUG 2

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 . at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 19 48 to 8/20 19 48.
and that I last saw him alive on 8/20 19 48.

Immediate cause of death Cardiac Failure
Due to Hypertensive c-v.
Due to Generalized toxemia
Due to Lobar Pneumonia right middle & lower
Other Conditions Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Venable, Jr. M.D.
Address St. Agnes Hospital Date signed 8/20/48

correct age is especially important. Physicians, please write plainly.

G66129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G66129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
1629 W. Lexington St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hollis Or Flory Hollins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1. 1885

8. AGE: Years 63 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Waterberry. A. A. Co. Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Galloway
13. Birthplace Waterberry A. A. Co. Md

MOTHER
14. Maiden Name Amelia Taska
15. Birthplace Calvert Co. Md

16 (a) Informant Jane Johnson
(b) Address 1629 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery. Cem.
Location Brooklyn. Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address Brantly Ave.

AUG 24 1948 (Date rec'd by registrar) (b) Huntingtown Md. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 . at 84 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17/48 19 . to 8/20/48 19 .
and that I last saw h[illegible] alive on 8/17/48 19 .

Immediate cause of death
Bronchi Pneumonia
Myocarditis acute
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
Unknown

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elroy O. Wilson M. D.
Address Owensdale Date signed 8/24/48

correct age is especially important. Physicians: please write the cause of death plainly.

G66130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓47D

G66130
Registered No.

ID 121403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Orleans Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy House

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Rose Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1900

8. AGE: Years 48 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Perry House
13. Birthplace N.C.

MOTHER
14. Maiden Name Savana Langley
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave/

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Chas. A. Wilson
(b) Address 1215 E. Baltimore ave

AUG 24 1948
(Date rec'd by registrar)

(b) Huntington Woods, Md.

VS 90

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 5:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19- 1948, to 8-22- 1948 and that I last saw h in alive on 8-22- 1948.

Immediate cause of death Resp. failure

Duration 1 day

Due to Ca of lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: Ca of lung, rt

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City Hosp Date signed 8-23-48

X

Correct age is especially important. Physicians: please write the exact number of years, months, days, hours, or minutes.

G66131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G66131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 S. Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Cullison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5 Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Cullison

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 15 1898

8. AGE: Years 50 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Cullison
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Henrietta Shorter
15 Birthplace St. Marys Co. Md.

16 (a) Informant James Lawson
(b) Address 40 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25. 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1009 Brantly Ave.

19 (a) AUG 24 1948
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug. 23 1948, and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death Myocarditis, Diabetes, Melitus, Nephritis

Duration ?

Due to [illegible]

Due to

Other Conditions abor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Angler M. D.
Address 1634 E. Baltimore Date signed 8/24/48

To be signed by Medical Examiner

VS 150

Please write clearly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G66132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66132 Registered No. 124 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE LYONS (GERTRUDE M. WELCH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louis Lyons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-1918

8. AGE: Years 30 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jerome J Sadler

FATHER 13. Birthplace Balto Co Md

MOTHER 14. Maiden Name Laura V McFaltridge

MOTHER 15. Birthplace Balto Co Md

16 (a) Informant

(b) Address 3505 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day)

(c) Cemetery or crematory Mt Olivet

Location Frederick Rd

18 (a) Funeral director Edward Foulkes

(b) Address 2317 Wash. Blvd

Huntington Williams, M.D.

19 (a) (Local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948 at 12:30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Upper Respiratory Infection

Other Conditions Fatty Degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L Royston M.D. Medical Examiner

Date signed August 23, 1948

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 15:

G66133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G66133

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Hamilton Ave. #14 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Edwards

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-01-5466

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Augusta Massaro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1877

8. AGE: Years 70 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Accountant
11. Industry or business Maryland Tobacco Co.

FATHER
12. Name Thomas Edwards
13. Birthplace England

MOTHER
14. Maiden Name Margaret McCrary
15. Birthplace Ireland

16 (a) Informant Malcolm M. Edwards
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Pinewood Cem.
Location Parkville, Balto. Co., Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948, to 8/22 1948, and that I last saw him alive on 8/22 1948.

Immediate cause of death: Pulmonary edema / Cardio-respiratory failure — Duration: 1 hour

Due to: Arteriosclerotic Heart Disease — ? years

Due to: Pneumonia, right base — 12 days

Other Conditions: Uremia — 12 days; Diabetes mellitus — ~~1 year~~

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann, M. D.
Address Maryland General Hosp. Date signed 8/22/48

93D

G66134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-1
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME JOSEPH PECORA

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 128-07-2192

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12, 1889

8. AGE: Years 59 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual Occupation Supt.

11. Industry or business Wm. T. Lyons Co., Inc.

FATHER
12. Name Domenick G. Pecora
13. Birthplace Italy

MOTHER
14. Maiden Name Agnes Marchese
15. Birthplace Italy

16 (a) Informant Mr. Anthony W. Pecora
(b) Address 46 Hudson Ave., Waldwick, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 12:45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature Homer J. Wilkens M.D.
Medical Examiner.
Date signed 8-23-48

VS 151

X

copy at age is especially important. If any mistake, please write the correct age in the space provided.

G66135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66135
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 851 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS WENTWORTH

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eva B. Wentworth
nee Hubert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1885

8. AGE:

Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Oliver E. Wentworth
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Catherine Hubbard
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Ferdinand A. Foertsch
(b) Address: 2638 Mathew St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 8 4 1948 (Date rec'd by registrar) Countersigned Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 4.15 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed August 23, 1948

correct age is especially important. Physicians: please write the

G66136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Darley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Darley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA S. RIGNEY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: John Rigney
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Aug. 31, 1861
8. AGE: Years 86 | Months 11 | Days 21 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: - Albin
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. Christian Wickland, son-in-law
(b) Address: 1607 Darley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: M. J. TICKNER & SONS
(b) Address: Balto., Md.

8/26/48 (c) Date rec'd by registrar (b) Huntington for Williams, M.D. Registrar

V.S. 150

correct age is especially important. Physicians: please write the cause of death plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 8:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/21 1948 to 8/21 1948 and that I last saw her alive on 8/21 1948

Immediate cause of death: Bronchopneumonia — Duration

Due to Arteriosclerotic-C.V.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian F. Riddle M. D.
Address 11 W. Biddle Date signed 8/26/48

6137 — G66137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 141 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5910 Falls Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: HARRY RAY WOODS

3 (b) If veteran, name war: VA I

3 (c) Social Security Account No.: 214-12-8505

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Feb. 26, 1893

8. AGE: Years: 55 | Months: 5 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business:

FATHER — 12. Name: Geo. Woods
13. Birthplace: Balto, Md.

MOTHER — 14. Maiden Name: Emmie Taylor
15 Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Rd Catonsville Md

18 (a) Funeral director: Geary F. Rutherford Co
(b) Address: 1735 Rutherford Ave

19 (a) AUG 24 1948 (Date received by Registrar) (b) Huntington Md (Registrar)

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1948 to Aug. 23 1948, and that I last saw him alive on Aug. 23 1948.

	Duration
Immediate cause of death: Postoperative state: craniotomy right temporal	
Due to:	
Due to:	
Other Conditions: Pulmonary atelectasis right upper & middle lobes (Include pregnancy within 3 months of death)	Several months
Date of operation: 4/19/48	
Major findings of operation: Mass in right hemisphere	
of autopsy: As above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 8/24/48 M.D.

X

66138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or [redacted]
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 N. Regester St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME: Seufert, Barbara Magdalene (Barbara M. Seufert)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Philip P. Seufert
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1874

8. AGE: Years 73 | Months 8 | Days 11 | If less than one day [redacted] min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Philip Hoffman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Huth
15. Birthplace Germany

16 (a) Informant Philip P. Seufert
(b) Address 1817 N. Regester Street

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location 4430 Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

AUG 24 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, 11:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19, 1948 to Aug. 23, 1948, and that I last saw her alive on Aug. 23, 1948.

	Duration
Immediate cause of death: Cerebral-Vascular accident	
Due to: Hypertensive Cardio-Vascular disease	
Due to: Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Ray E. Person Jr. M. D.
Address St. Joseph's Hospital Date signed Aug 23, 1948

X

VS 150

correct age is especially important. Physicians: please write plainly and use ink or indelible pencil

139 BC – 48-176EE

AB-122293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. C66139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Shrs-life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Parry Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 21-1948

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charlie Berry
13. Birthplace S.C.

MOTHER
14. Maiden Name Archiebell Evans
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug 23 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Crematory
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 AUG 24 1948 (Date rec'd by Registrar) (b) Washington H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21- 1948, at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1948 to 8-21- 1948, and that I last saw h[illegible] or alive on 8-21- 1948.

Immediate cause of death Prematurity — Duration 8 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Aug 23

VS 150

correct age is especially important. [illegible]

G66140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G66140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3416 Virginia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimpre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Josephine Whyte.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Albert M. Whyte.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1876

8. AGE: Years 72 | Months 3 | Days 9 | If less than one day: hr. min.

9. Birthplace Easton, Pa.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name Schultz,
13. Birthplace unknown,

MOTHER
14. Maiden Name unknown,
15. Birthplace unknown,

16 (a) Informant Mr. Albert M. Whyte.
(b) Address 3416 Virginia Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.,
(c) 1948 AUG 24 (Date rec'd by registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 7. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 19[illegible] to 8/23 1948, and that I last saw her alive on 8/22 1948.

Immediate cause of death CARCINOMA of PANCREAS — Duration 9 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Lein M. D.

Address 4818 Reisterstown Rd. Date signed

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

V S 190

G66141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Westport (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin John Kilbourne

3 (b) If veteran, name war: WW #2
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1907

8. AGE: Years 40 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Guard
11. Industry or business Bay Highway Shipyard

FATHER
12. Name Frank Kilbourne
13. Birthplace Md

MOTHER
14. Maiden Name Nancy E. Cooden
15. Birthplace Md

16 (a) Informant Nancy E. Kilbourne
(b) Address 2411 Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave

18 (a) Funeral director John F. Penny Inc
(b) Address 715 Light St.

19 AUG 25 1948 (Date rec'd by Local Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1946, to Aug. 23 1948, and that I last saw him alive on Aug. 7, 1948.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Hypertensive Cardio-Vascular Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel C. Wolfe, M.D.
Address 1334 E. Monument Date signed 8-24-48

VS 150

6142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G66142 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mar
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Pontiac Ave #25 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/16/83

8. AGE: Years 65 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Mover

11. Industry or business

FATHER
12. Name George W. Elliott
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Sylvia
15. Birthplace Virginia

16 (a) Informant Mrs Grace Elliott
(b) Address 410 Pontiac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St. -30

19 AUG 25 1948 (Date received by Registrar) (b) Funeral for Williams, Mr.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1948, at 2254 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 19 48 to 8/26 19 48 and that I last saw h i m alive on 8/23 19 48.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Carcinomatosis C Prostate	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Blazek M.D.
Address Maryland Ave Date signed 8/24/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and report correct age is especially important.

VS 153

937

G66143

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH / 61

Registered No. G66143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MONTHS 8 DAYS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ANNE ARUNDEL
(c) City or town BROOKLYN, MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 DORIS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SCHNEPFE, NANNIE A.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daniel Schnepfe

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) August 11, 187[illegible]

8. AGE: Years 71 | Months | Days 11 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

12. FATHER Name Curtis M. Lee

13. FATHER Birthplace Md

14. MOTHER Maiden Name Almeda Jacobs

15. MOTHER Birthplace Md

16 (a) Informant Mr Daniel Schnepfe

(b) Address 500 Doris Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F Flannery Inc

(b) Address 715 Light St

AUG 25 1948 (Date rec'd by Registrar)

(b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22 1948 at 7[illegible]5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15 1948 to AUG 22 1948. and that I last saw HER alive on AUG 22 1948.

	Duration
Immediate cause of death HYPOSTATIC PNEUMONIA	
CARDIO RESP. FAILURE	
Due to ARTERIOSCLEROSIS GENERALIZED	
Due to DIABETES MELLITUS	
MIDTHIGH AMPUTATION (RT.)	
Other Conditions (POST OP.)	

(Include pregnancy within 3 months of death)

Date of operation MIDTHIGH AMP. 8/6/48

Major findings of operation: ARTERIOSCLEROSIS

of autopsy: ARTERIOSCLEROSIS, PNEUMONIA

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Cooper Jr M. D.

Address SOUTH BALTO. GEN HOSP Date signed 8/22/48

PLEASE WRITE PLAINLY, with UNFADING INK, and write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 MARSHALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 DA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 MARSHALL ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME ANNA HUSTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife GEORGE HUSTER
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) JAN. 9, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	13	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name AUGUST OTTO
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA WEISS
15 Birthplace GERMANY

16 (a) Informant P. AUGUST GRILL
(b) Address 1204 FIDELITY BLDG

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory LAUDUN PK.
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST. 230

19 (a) AUG 25 1948 (b) Huntington-Williams F.H.
(Actually buried or cremated) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1948 to 8-21 1948 and that I last saw h[illegible] alive on 8-21 1948

Immediate cause of death	Duration
Auricular fibrillation	
Due to myocardial degeneration	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Denis McGrath M.D.
Address 1E. Randall St. Date signed 8/23/48

66145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Gelston Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Gelston Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Balsis

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4493

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	married

6 (b) Name of husband or wife Ursula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Ursula Balsis
(b) Address 3814 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 25 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Road

18 (a) Funeral director Joseph Kaasmeyer Inc
(b) Address 602 Wash Blvd

19 AUG 25 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1948, at 10 05 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to Arteriosclerosis Generalized

Other Conditions Senility
Contusion Left eye.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E McFadden M.D.
Medical Examiner.
Date signed 8-24-48

VS 131

correct age is especially important, as it affects...

5146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66146
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 George St.
(c) Hospital or institution: Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Thomas Blagman.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. 5. Color or race C. 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Robert Garnett.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1903
8. AGE: Years 45. Months Days If less than one day hr. min.
9. Birthplace St. Michels Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frank Thomas.
13. Birthplace St. Michels

MOTHER
14. Maiden Name Unknown.
15. Birthplace St. Michels

16 (a) Informant Mrs Ellen Pearson
(b) Address 736 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port Balto. Md.

18 (a) Funeral director Metropolitan Fun. Home Inc.
(b) Address 907 N. Mount St.

AUG 25 1948 (Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1948 at 8.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/23 1948, and that I last saw her alive on 8/23 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 7 Days
Due to
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Garner
Address 736 George St. Date signed 8/24/48 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G66147
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904± Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MORRIS KLING

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE	Years	Months	Days	If less than one day
	63			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Philip
13. Birthplace Russia

MOTHER
14. Maiden Name Lapkin
15. Birthplace Russia

16 (a) Informant Lena Kling
(b) Address 3904± Boarman Ave
17 (a) Burial Sinai (b) Date thereof 8-25-48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sinai Israel
Location Northern Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place
AUG 25 1948 (Date received by Registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1948, at 9:05 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948, to Aug. 24 1948, and that I last saw h[illegible] alive on Aug 24 1948.

	Duration
Immediate cause of death Bronchopneumonia	
Due to	
Due to	
Other Conditions Hypernephroma c metastases (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Bronch. Hypernephroma Cystic.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address Sinai Hosp. M. D. Date signed 8-24-48

PLEASE WRITE PLAINLY with correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

G66148 G66148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Jail Infirmary
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 W Fitzhugh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Gunning (colm)

3 (b) If veteran, name war WWI

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lottie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1891

8. AGE: Years 57 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Texas Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael J Gunning

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Wahnum

15. Birthplace Ireland

16 (a) Informant Mrs Lottie Gunning

(b) Address 716 Kendall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 26 48 (month) (day) (year)

(c) Cemetery or crematory National

Location Baltimore Md

18 (a) Funeral director Pellman Funeral Home

(b) Address 1217 E Fayette St

19 (a) AUG 25 1948 (b) Entered by Pellman, Md
Date rec'd by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948 at 3 45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While (at) work?
(d) Means of injury

23. Signature E R Long M.D. Medical Examiner.
Date signed 8-24-48

correct age is especially important. [illegible]

G66149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948 B866148

Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 GRANBRY ST
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Granby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTHEW MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 10. 1871

8. AGE: Years 76 | Months 10 | Days 13 7 | If less than one day hr. min

9. Birthplace CALIFORNIA (Town, county, and state)

10. Usual Occupation SHIP WATCHMAN

11. Industry or business

FATHER
12. Name MICHAL JOS MOORE
13. Birthplace DUBLIN IRELAND

MOTHER
14. Maiden Name ELLEN TOY
15. Birthplace IRELAND

16 (a) Informant: GEORGE T MOORE
(b) Address 3656 N. LAKEWOOD CHICAGO-ILL

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 24-4 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MD

18 (a) Funeral director ELLSWORTH HAMMOND
(b) Address 3911 LIBERTY HEIGHTS AVE Baltimore 29 Maryland

19 (a) AUG 25 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 6.20p M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio-sclerotic - C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed August 18, 1948

correct age is especially important. Physicians: please write all causes of death clearly.

VS 151

66150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County Long Island
(c) City or town East Hampton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Chester Marts Cloud.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: May Christine Cloud
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Apr 4 1884.

8. AGE: Years 64 | Months 4 | Days 20 | If less than one day: hr. min.

9. Birthplace: Woodbury N.J. (Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Mr Josiah G Cloud
13. Birthplace: Mt. Ephram N. J.

MOTHER
14. Maiden Name: Lucille W Marts
15. Birthplace: Mauricetown N.J.

16 (a) Informant: Mr. G. Walther Ewalt
(b) Address: Beverly Hall, Millersville, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Crematory
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 25 1948 (b) Registered [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1948, at 9 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1948. to Aug 24 1948. and that I last saw him alive on Aug 20. 1948.

Immediate cause of death: Pulmonary Congestion — Duration 48 hrs.

Due to: Hypertensive Arterio-sclerotic Heart Disease — Duration 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John R. Smith Jr. M.D.
Address: Union Memorial Hospital
Date signed 8/27/48

correct age is especially important. Physicians, please cooperate.

VS 159

66151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 66151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Francis St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Francis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thaddeus S. Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no		male	white	divorced

6 (b) Name of husband or wife Thelma Irene Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Balto. Transit Co.
11. Industry or business Retired

FATHER
12. Name Ellsworth D. Johnson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alverta Bennett
15. Birthplace Balto., Md.

16 (a) Informant Mrs. E. T. Bowling, daughter
(b) Address 5009 Beaufort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Md.

18. (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 24 1948 at 11 20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to Arteriosclerosis Generalized

Other Conditions Cerebro-Vascular Accident (old).
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-24-48

correct age is especially important. Report

VS 151

66152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 S Smallwood St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 S Smallwood St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Cecelia Singer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-1888

8. AGE: Years 60 | Months 6 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore City
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Singer
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Gias
15. Birthplace Germany

16 (a) Informant Sadie E Saunders
(b) Address 335 S Smallwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Robt C. V. B'dn. Walters
(b) Address Pratt & Shuckers Sts

19 (a) AUG 25 1948 (Date received by registrar)
(b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 8/24 1948 and that I last saw her alive on 8/23 1948.

Immediate cause of death Myelogenous Leukemia — Duration 18 mos

Due to Myelogenous

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury —

23. Signature Albert D. Kahn M. D.
Address 2030 Wilkens Ave
Date signed 8-27-48

correct age is especially important. Physicians, please give the exact

X

66153

AB-122082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willnett Birdsong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Marney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept-8-1896

8. AGE: Years	Months	Days	If less than one day
51	11	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Blake (D
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Brown
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug. 26, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Geo. W. Hyldon
(b) Address 631 Druid Hill Ave.

AUG 25 1948
(Date rec'd by registrar)

(by) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21- 1948, at 9.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1948 to 8-21- 1948, and that I last saw her alive on 8-21- 1948.

Immediate cause of death
Uremia — Duration 2 wks.

Due to Hypertensive cardio-vascular-renal disease — 5 yr.

Due to

Other Conditions Pulmonary Edema — 3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Hypertensive Cardio vascular renal disease

of autopsy: Hypertensive Cardiovascular Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 8-22-48

correct age is especially important

(VS 15)

6154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144 B

Registered No. G66154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4831 Keswick Rd.
(c) Hospital or institution:

27-14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4831 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette F. Griffin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 18 1929

8. AGE: Years	Months	Days	If less than one day
18	10	5	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John R. Griffin
13. Birthplace Md.

MOTHER
14. Maiden Name Beulah F. Mitchell.
15. Birthplace Md.

16 (a) Informant John R. Griffin
(b) Address 4831 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Paul E. Clemmenth Jr.
(b) Address 2405 N. Chester St Ave.

19 AUG 25 1948 (Date filed by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at 7.20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1948 to Aug 23 1948 and that I last saw her alive on Aug 23 1948.

Immediate cause of death Hodgkin's Disease — Duration 5 years

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Pearce M. D.
Address 205 N Chester St Date signed Aug 25 1948

correct age is especially important. Physicians: please write in ink.

VS 150

X

6155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp - 6 - DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE CORNISH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace " "

MOTHER 14. Maiden Name unknown

15. Birthplace " "

16 (a) Informant Annie Jones

(b) Address 1502 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Brooklyn Md

18 (a) Funeral director Thos O. Wilson

(b) Address 1100 Bellentley ave

19 (a) AUG 25 1948 (Date rec'd by registrar) (b) Huntington Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/1948, at 6 10 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Edgar F. Merrill M.D.
Medical Examiner.

Date signed 8/24/48

correct age is especially important. Physicians: please write the cause of death plainly.

6156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66156

correct age is especially important. Physicians: please write the causes of death plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Jasper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Jasper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No. 216-12-9615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1872

8. AGE: Years	Months	Days	If less than one day
76	10	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Waters Caterer

FATHER
12. Name Isaac Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Smith
15. Birthplace Maryland

16 (a) Informant James A. Jones
(b) Address 406 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Arbutus, Md.

18 (a) Funeral director Charles F. Law
(b) Address 802 Madison Ave.

19 (a) AUG 25 1948 (Date received by Registrar) (b) Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Aug. 1948, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebro-Sclerosis - C.V.
Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 22 Aug 48

6157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G66157

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 E.28th., Street
(c) Hospital or institution: 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E.25th., Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Joseph DeBaufre

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-14-4544

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Iris Ann Hoffman
6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) May 30, 1922

8. AGE: Years	Months	Days	If less than one day
26	2	23	###### min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business Mc Carthy-Hicks Co.,

FATHER
12. Name Benjamin DeBaufre
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Lynch
15 Birthplace Baltimore, Md.

16 (a) Informant George DeBaufre--Brother
(b) Address 1452 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Morlands Park
Location Taylor Avenue, Balto. Co. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 AUG 25 1948 (Date rec'd by registrar) (b) Burington for Baltimore, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23rd., 1948 at 6-P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1948 to 8/23 1948.
and that I last saw h[illegible] alive on 8/22 1948.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Rheumatic Heart Disease — 2 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Blum M. D.
Address 114 N. Calvert Date signed 8/24/48

G66158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66158
Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4700 Harford Rd.
(c) Hospital or institution:
Mrs Snyders Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAVINIA KING

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1863

8. AGE: Years 84 | Months 9 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? King
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs John Myers
(b) Address 3722 Rexmere Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/ 25/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

AUG 25, 1948 (Date received by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1948 to Aug 22 1948
and that I last saw him alive on Aug 22 48

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other Conditions: Cirrhosis of Liver, Partial Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Gudtman M. D.
Address 315 Thurston Ave. Date signed 8/23/48

VS 150

G66159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

G66159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 Inglewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Inglewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE PENDELTON BAUER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife: John J. Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	11	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George Stiff
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Nettie Wood
15. Birthplace: Virginia

16 (a) Informant: Mrs Frederick Ball
(b) Address: 2715 Inglewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

AUG 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: August 23, 1948 at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1948 to Aug 23 1948, and that I last saw her alive on Aug. 20 1948.

Immediate cause of death: acute cardiac dilatation — Duration: 20 min.
Due to: carditis. — 3 yrs.
Due to:
Other Conditions: arterio-sclerosis, hypertension, diabetes. — 2
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: L. E. Whitehead
Address: 447 N. Kenwood Ave Date signed: Aug 24 1948

VS 190

95c

PLEASE WRITE PLAINLY with ink or indelible pencil. Physicians: please write the causes of death clearly, and report correct age is especially important. Physicians are required by law to report deaths to the Registry.

G66160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G66160
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bass, Sylvia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1876

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis Yarisoffski
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Abraham Potlock
(b) Address 4410 Towanda Ave.

17 (a) Burial (b) Date thereof Aug. 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowley Lane

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1126 W. North Ave.

19 (a) (b) Registrar
(Date rec'd by registrar) AUG 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 8 1/2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug 25 1948, and that I last saw h er alive on Aug 25 1948.

Immediate cause of death Intracerebral hemorrhage, rt — Duration 20 hrs

Due to Arteriosclerotic & Hypertensive cardiovascular disease — many years

Due to (Cardiac enlargement) (Calcific aortic sclerosis)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Maurice D. Davis M. D.
Address West Balto. Gen. Hosp Date signed 8-25-48

correct age is especially important. Physician: please write plainly.

G66161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G66161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK PHILIP FABY, Jr. smt

3 (b) If veteran, name war: WW II | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: STELLA FLORENCE FABY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST-15-1919

8. AGE: Years 29 | Months - | Days 9 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation POLICE

11. Industry or business NORTH EAST DISTRICT

FATHER
12. Name FRANK FABY
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name MARY BUNK
15. Birthplace UNKNOWN

16 (a) Informant STELLA FLORENCE FABY
(b) Address 822 SOUTH KENWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (date) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE MD

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann st

19 (a) 8-25-1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH August 24, 1948, at 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill, M.D.
Medical Examiner.
Date signed 8-24-48

666162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

666162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Liberty Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN Alfred BLUM

3 (b) If veteran, name war World War #2

3 (c) Social Security Account No. 219-20-1398

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1925

8. AGE: Years	Months	Days	If less than one day
22	7	29	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation UNKNOWN

11. Industry or business

FATHER
12. Name William A. Blum
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Denform
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Buried (Burial, cremation, or removal) **(b) Date thereof** 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Sandymount
Location Finksburg, Maryland

18 (a) Funeral director Francis Reese
(b) Address Westminster, Md.

19 (a) Date received AUG 25 1948 (b) (registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed chest
Ruptured inferior vena cava

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-48 at 3:00 A.M.
(b) Where did injury occur? Reisterstown Rd. 200' S. of Roaches Lane
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
Means of injury Auto into parked auto

23. Signature Emil Beyer M.D.
Medical Examiner.
Date signed 8-25-48

correct age is especially important. Physicians: please write the cause of death clearly

G66163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G66163

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 22 N. Carey St.
(c) Hospital or institution: Good Samartian Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Wesley Carlyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary B. Carlyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	11	26		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Lather
11. Industry or business

FATHER
12. Name Henry W. Carlyle
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary E. Meseroll
15. Birthplace New Jersey

16 (a) Informant Miss Irene D. Carlyle
(b) Address 627 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wells Funeral
(b) Address 1003 W. Baltimore St.

AUG 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18/48 19.. to 8/23/48 19.., and that I last saw him alive on 8/18/48 19..

Immediate cause of death Coronary Thrombosis Duration Minutes

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. F. Loos M. D.
Address 4012 Edmondson Ave Date signed 8/24/48

VS 150

G66164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

183

G66164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Foot of Ann Street

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD HANSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE:	Years	Months	Days	If less than one day
	63			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory Loraine Gun Cemetery

Location York Road.

18 (a) Funeral director Ellsworth Arnacost

(b) Address 3911 Liberty Heights Ave

19 (a) 1948 (Date rec'd by reg.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1948, at 6:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found: 8-21-48 at 6:15 A.M.

(b) Where did injury occur? Found: Harbor: Ft. of Ann St.

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? no

(d) Means of injury Falling Drowning

23. Signature Earl K. Rowe M.D.
Medical Examiner.

Date signed 8-23-48

2/3

certain age is especially important. Physicians: please write the cause of death clearly, using

G66165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66165 Registered No.

87

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Augusta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine L. McDermott

3 (b) If veteran, name war: No
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1913

8. AGE: Years	Months	Days	If less than one day
35	0	14	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Domestic Work
11. Industry or business With Private Families

FATHER
12. Name Patrick J. McDermott
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah A. Knight
15 Birthplace Ireland

16 (a) Informant Mrs. Nora Rowland
(b) Address 1624 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location 4730 Old Frederick Rd.

18 (a) Funeral director Charles W. Conklin
(b) Address 924 E. Eager St.

AUG 25 1948 (b) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/48 19 to 8/24/48 19, and that I last saw h.. alive on 8/24/48 19.

Immediate cause of death
Acute Myocarditis — Duration: few hours
Due to Multiple Seizures — Duration: 11
Due to Uterine Hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Doran M. D.
Address 20 E. Eager St. Date signed 8/25/48

Please write plainly. Physicians: please write the causes of death exactly and correct age is especially important.

G66166 ✓ G66166

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Peach Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Addie Williams

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Pearl Evans

13. Birthplace Ga.

MOTHER 14. Maiden Name Mollie Borrington

15. Birthplace Ga.

16 (a) Informant Charles Williams

(b) Address 1023 Peach Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director James A. Davis

(b) Address 1142 Hollins St.

19 (a) Aug 25 1948 (Date received by registrar) Washington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1948, at 2:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Embolism

Due to Mesenteric Thrombosis

Due to Thyrotoxicosis

Due to Fracture Pelvis

Other Conditions Internal Derangement of Rt Knee

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23/

(a) Date of injury July 24, 1948, 11:45 p.m. M.

(b) Where did injury occur? Hanover & Henrietta Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Intersection While at work? No

(d) Means of injury Struck by truck

23. Signature Carl L. Voss M.D. Medical Examiner.

Date signed 8/23/48

correct age is especially important. Physicians: please write the cause of death plainly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road + Herring Run
(c) Hospital or institution: Sydenham
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Alberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. ?, 1910

8. AGE: Years	Months	Days	If less than one day
37	9		hr. min.

9. Birthplace Winston-Salem, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Matthews

13. Birthplace ?

MOTHER 14. Maiden Name ?

15 Birthplace ?

16 (a) Informant wife

(b) Address 602 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location Baltimore Md

18 (a) Funeral director Clay S. Wilson

(b) Address 1000 Brantley ave

Aug 25 1948 Lexington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 2:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1948, to Aug 23, 1948, and that I last saw him alive on Aug 23 1948.

Immediate cause of death	Duration
Lt. Hemiplegia, Coma, Acidosis	
Due to Questionable Cerebral Vascular Accident or	
Due to Questionable Intracranial Neoplasm	
Other Conditions Previous partial gastrectomy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Porter M. D.

Address Sydenham Hosp. Date signed 8-25-48

V S 150

A certificate of death is especially important. Physicians: please write the cause of death clearly and correct age is especially important.

G66168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G66168

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County

(c) City or town Akron (If outside city or town limits, write RURAL and give town)

(d) Street No. R.D. Box 756 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) **FULL NAME** Arthur Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-24

8. AGE: Years	Months	Days	If less than one day
19	5	22	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Valentine Miller

13. Birthplace Pa

MOTHER 14. Maiden Name Agnes 2

15. Birthplace Pa

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 25th (month) (day) (year)

(c) Cemetery or crematory

Location Akron Ohio

18 (a) Funeral director Ulrich Funeral Home

(b) Address 200 E. Orleans St

19 (a) Aug 25 1948 (Date received by registrar) (b) Huntington, West Virginia (Registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 25 1948 and that I last saw h[illegible] alive on Aug 25 1948.

Immediate cause of death Hemorrhagic Shock — Duration

Due to Operation - Exploration, Gastrectomy

Due to Congenital Heart Disease Tetralogy of Fallot

Other Conditions [illegible]

(Include pregnancy within 3 months of death)

Date of operation Aug 25, 1948

Major findings of operation See above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. A. Cooley M.D.

Address JOHNS HOPKINS HOSPITAL Date signed Aug 25 48

Report age is especially important. Physicians, please

66169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 66169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 N. Gilmore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee Hatchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Elizabeth Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/90

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Hatchett
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va.

16 (a) Informant Elizabeth Hatchett
(b) Address 1532 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 26, 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore, Md.

18 (a) Funeral director Geo. E. Pelton
(b) Address 1303 Pennsylvania Ave.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from August 23, 1948 to August 24 1948, and that I last saw him alive on August 24, 1948.

Immediate cause of death	Duration
Generalized tuberculosis	
Due to	
Due to	
Other Conditions Generalized tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy E. Pelton Jr. M.D.
Address 1303 Pennsylvania Ave. Date signed 8/24/48

2002

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

66170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill all blanks; if unknown, write unknown. Give full name of deceased. Do not abbreviate. Write the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4258 Falls Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4258 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Jones, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Helena E. Jones
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 187 4

8. AGE: Years 74 | Months 7 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business retired

FATHER
12. Name Benjamin W. Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Jennings
15. Birthplace Maryland

16 (a) Informant Mrs. Helena E. Jones
(b) Address 4258 Falls Rd. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Messiah Lutheran
Location Berrett, Carroll Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Aug 1948 to 24 Aug 1948 and that I last saw ~~him~~ alive on 14 Aug 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 2 years

Due to Generalized Arteriosclerosis — 7 years

Due to

Other Conditions Malnutrition Secondary to generalized Paralysis — 2 mos
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 2020 N Charles St Date signed 24 Aug 48

VS 150

66171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 66171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 945-W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore (If outside city or town limits, state RURAL District and township)
(d) Street No. 945-W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armiel Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 1877

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER 12. Name ?
13. Birthplace Md.

MOTHER 14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Leona Morgan
(b) Address 945- W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918- Lincoln St Hyattsville for Williams & Co.

19 (a) AUG 26 1948 (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Aug 1948 at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to h death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis

Due to

Other Conditions Generalized A.S. C.V. Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 21 Aug at 10 18/ A. M.
(b) Where did injury occur? 945 W. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from window

23. Signature Emil Kruger M.D.
Medical Examiner
Date signed 22 Aug 48

correct age is especially important. Physicians: please write the cause of death plainly.

G66172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G66172 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County Route 1
(c) City or town Odessa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marjorie Nall (MARJORIE NALL)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Adrian H. Nall
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) 7-28-99
8. AGE: Years 49 | Months 0 | Days 27 | If less than 1 day: hr. min.
9. Birthplace: Fla. (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

FATHER
12. Name: Frank Bushnell
13. Birthplace: Minn.

MOTHER
14. Maiden Name: Alice Creelman
15. Birthplace: Canada

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/ 48 (month) (year)
(c) Cemetery or crematory: Dade City Cemetery
Location: Florida

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 26 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/25 1948 and that I last saw h alive on 8/25 1948.

Immediate cause of death: Intracerebral Hemorrhage — Duration

Due to: Thrombocytopenic purpura, idiopathic

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Norman E Chaves M. D.
Address: JOHNS HOPKINS HOSPITAL Date signed 8-25-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G661173

G661173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Culver

3 (b) If veteran, name war: Spanish American War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Daniels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1874

8. AGE: Years 74 | Months 5 | Days 6 | If less than one day: hr. min. 19

9. Birthplace Sweet Valley Water Tenn (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Levin Culver
13. Birthplace Tennessee

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Records
(b) Address US Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) AUG 26 1948 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 48 to August 21 19 48, and that I last saw h im alive on Aug. 21 19 48.

Immediate cause of death: Carcinoma of prostate with metastasis to left kidney and supra-clavicular nodes — Duration: Approximately 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8-21-48

VS 190

correct age is especially important

6174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 666174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Linden Ave.
(b) Street address 2402 Edmondson Ave.
(c) Hospital or institution: Maryland General Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days 23 years
(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine W. E. Lotz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ late Fredrick Lotz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 5, 1876

8. AGE: Years 72 | Months 7 | Days 6 | If less than one day: 12 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry C. Quental
13. Birthplace France

MOTHER
14. Maiden Name Katherine Flatman
15. Birthplace Germany

16 (a) Informant F. W. Lotz
(b) Address 5312 Fern Park

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 26 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location 3801 FREDERICK AVE

18 (a) Funeral director Henry [illegible]
(b) Address 4101 Edmondson Ave
AUG 26 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1948, to Aug 23 1948, and that I last saw her alive on Aug 23 1948.

Immediate cause of death: dissecting aneurysm abdominal aorta — Duration

Due to arteriosclerosis.

Due to

Other Conditions arteriosclerotic cardio vascular disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Betty Mary Young M. D.
Address Maryland General Hospital Date signed 8/23

VS 15)

Please write in ink. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G66175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G66175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Make entries in all items. If unknown, or not applicable, write none. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3658 Buena Vista Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 + 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3658 Buena Vista Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel E. Robertson.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-3535

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche P. Robertson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business Lockner's Cafe

FATHER
12. Name John W. Robertson.
13. Birthplace Maryland,

MOTHER
14. Maiden Name Anna Edwards.
15. Birthplace Maryland.

16 (a) Informant Blanche P. Robertson.
(b) Address 3658 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Gustav E. Lowe
(b) Address 3638 Pulaski Ave.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 11.30 p.m

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Aug 24 1948; and that I last saw him alive on Aug 24 1948

Immediate cause of death Cardiac Coronary Occlusion — Duration 6 mo

Due to Coronary Arteriosclerosis — 10 yrs

Due to General Coronary Insufficiency — 2 yrs

Other Conditions /

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert M. Pooley, M.D.
Address 2527 St. Paul St Date signed Aug 26-48

VS 150

G66176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G66176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLADYS CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Carter.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1908

8. AGE: Years 39 | Months | Days | If less than one day: hr. min.

9. Birthplace Lancaster County Virginia (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Richard Jones.

13. Birthplace Lancaster County Va.

MOTHER 14. Maiden Name Addie Tompkins.

15. Birthplace Lancaster County, Va.

16 (a) Informant William Carter.

(b) Address 1315 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1948 (month, day, year)

(c) Cemetery or crematory Heathsville

Location Northumberland Co. Va.

18 (a) Funeral director Mrs Katie B. Williams

(b) Address 322 N. Schroeder St

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS t51

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 2.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull
Laceration of brain
Fracture of right humerus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-23-48 at 1.30 a. M. In front of Campbell Cement Co., Route #40 nr. Whitemarsh

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury Trailer truck sideswiped auto

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed August 23, 1948

correct age is especially important. Physicians: please write plainly.

66177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1924

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Lancaster County, Virginia (Town, county, and State)

10. Usual Occupation maid

11. Industry or business

FATHER 12. Name Joseph G. Carter.

13. Birthplace Lancaster County, Va.

MOTHER 14. Maiden Name Rachel Johnson.

15. Birthplace Lancaster County, Va.

16 (a) Informant: William Carter,

(b) Address 1315 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1948 (month, day, year)

(c) Cemetery or crematory Heathsville

Location Northumberland Co. Va.

18 (a) Funeral director Mrs. Nettie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) AUG 26 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948 at 2.30 a.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral cause

Postchiasmal Hemorrhage of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-23-48 at 1.30 a.M

(b) Where did injury occur? in front of Campbell Cement Co., Route #40 nr. Whitemarsh

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury Trailer truck sideswiped auto

Signature George G. Merrill M.D. Medical Examiner.

Date signed August 23, 1948

correct age is especially important. Physician...

666178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 666178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3917 REXMERE AVE.
(c) Hospital or institution: ******* ******
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 REXMERE AVE. (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT LANG

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0133

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ELLA A. LANG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 14, 1876

8. AGE: Years 71 | Months 9 | Days 9 | If less than one day ******** min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation STEEL CLIPPER
11. Industry or business C.T. BRANDT CO.

FATHER
12. Name CHARLES LANG
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY LANG
15. Birthplace GERMANY

16 (a) Informant MRS. ELLA A. LANG (WIFE)
(b) Address 3917 REXMERE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address AUG 26 1948 2200 EUTAW PLACE. . 17

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 23rd. 1948 at 8;06 M P

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 12, 1945, to AUG. 23 1948.
and that I last saw h[illegible] alive on AUG. 23 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr.
Due to: Hypertension Cardio-vascular renal disease — Duration: 3 yrs.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd C. Taylor M.D. M. D.
Address 3902 Greenmount Ave. Date signed

6179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C66179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 Harford Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Melfa

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Carmela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-28-1884

8. AGE: Years	Months	Days	If less than one day
63	7	28	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francisco Melfa
13. Birthplace Italy

MOTHER
14. Maiden Name Liberia Migliazzo
15. Birthplace Italy

16 (a) Informant Mr. Frank Melfa
(b) Address 2617 E. Oliver St.

17 (a) Burial (b) Date thereof 8-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.

19 (a) AUG 26 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 19 48 at 1.37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 19 48 to 8-25 19 48, and that I last saw him alive on 8-25 19 48

Immediate cause of death Cerebral hemmorrhage — Duration 1 day

Due to

Due to

Other Conditions Lobar pneumonia
Chronic passive congestion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: General arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ann Powell, M.D.
Address Date signed 8-25-48

correct age is especially important. Physicians, please write plainly.

VS 150

8-30a

6180

B-122250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 39c

Registered No. G66180

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4219 Erdman Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME B. Frank Kroeger

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-16-9629A

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie May Kroeger nee Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7- 1874

8. AGE: Years 74 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)

10. Usual Occupation X Night Watchman

11. Industry or business Geo. P. Mahoney Co.

FATHER

12. Name X Unknown

13. Birthplace X "

MOTHER

14. Maiden Name X "

15. Birthplace X "

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1948 to 8-24- 1948 and that I last saw h im alive on 8-24- 1948

Immediate cause of death: Probable Rocky Mountain Spotted Fever — Duration: 10 days

Due to

Due to

Other Conditions Bronchopneumonia, left lung — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, left lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. Sturtzman M. D.

Address Balto. City Hosp. Date signed 8-25-48

correct age if especially large

VS 180

1795

66181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 B

Registered No. G66181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Wise St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KIOUSSIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife THEODORE

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JUNE 18, 1911

8. AGE: Years	Months	Days	If less than one day
37	2	6	hr. min.

9. Birthplace MASSACHUSETTS (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name	PETER LOOMIS
FATHER 13. Birthplace	GREECE
MOTHER 14. Maiden Name	DESPINA THEODORES
MOTHER 15. Birthplace	GREECE

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Rambo & Jones
(b) Address 438-40 E. North Ave Baltimore, Md.

19 (a) AUG 26 1948 (Date received by Registrar)

VS 150 To be Approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948, to 8-24 1948, and that I last saw her alive on 8-24 1948.

Immediate cause of death	Duration
Uremia	
Due to Renal failure	
Due to Bichloride of mercury poisoning	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Suicide
(b) Date of occurrence 8-15-48 at 8 P M
(c) Where did injury occur? Baltimore, Balt. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work? No
(e) Means of injury Bichloride of mercury

Certification to be made by Medical Examiner.

23. Signature [illegible] M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

66182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13-1a

✓ Registered No. 66182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St
(c) Hospital or institution:
Home for Incurables 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Belle Sutherland.

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27, 1872

8. AGE: Years 75 | Months 10 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John M. Sutherland
13. Birthplace Ireland.

MOTHER
14. Maiden Name Suzanna M. Michael
15. Birthplace Harford Co. Md.

16 (a) Informant Records of Home for Incurables
(b) Address 700 W. 40th St. Baltimore. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John Mitchell & Sons Inc.
(b) Address 1630 Eutaw Place

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1938 to 8/24 1948, and that I last saw her alive on 8/24 1948.

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease — Duration 15 years

Due to

Due to

Other Conditions Atrophy of Legs secondary to Poliomyelitis — Duration 68 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Heraperger M. D.
Address 214 Medical Arts Bldg Date signed 8/25/48

X

correct age is especially important. Physicians, please write

VS 150

G66183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 937

G66183
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 N. Eden St.
(c) Hospital or institution:

4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1898

8. AGE: Years	Months	Days	If less than one day
49 50	10	24	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles Ford
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Jackmond
15 Birthplace Va.

16 (a) Informant Rosetta Paige
(b) Address 1408 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs Ruth M. Ellsworth
(b) Address 1129 N. Carlton St

19 (a) AUG 26 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Aug 1948 to 23 Aug 1948 and that I last saw h er alive on 23 Aug. 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	6 mos.
Due to hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clifford P Dunn M. D.
Address 2309 Druid Hill Date signed 8-25-48

correct ago is especially important. If unknown, please write

VS 150

G66184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G66184

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3705 Egerton Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3705 Egerton Road (If rural give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME Katie Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name Julius

13. Birthplace Russia

MOTHER

14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Sam T. Schevey

(b) Address 3705 Egerton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philip Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Gutay St Huntington Station Baltimore, Md

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1948, at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Aug 26 1948 and that I last saw her alive on Aug 26 1948

Immediate cause of death: Coronary occlusion — Duration: 3 days

Due to: Coronary Heart Disease — 3 years

Due to: senility

Other Conditions: Diabetes Mellitus (mild) (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leonard Wallenstein M. D.

Address 848 N 36th St Date signed 8/26/48

Correct age is especially important. Physicians, please write plainly.

VS 150

94a

AI-12236 G66185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G66185
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Democracy Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Stella Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Roy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10-1885

8. AGE: Years 63 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Thomas Rhodes
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/48 (month) (day) (year)
(c) Cemetery or crematory Bel Air Burial Park
Location Bel Air, Md

18 (a) Funeral director Joseph T Fulton
(b) Address Bel Air Md

19 (a) Aug 1948 (b) Registrar Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 1.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-26 1948, and that I last saw her alive on 8-26 1948.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Cerebral Hemorrhage & right hemiplegia — 3 days

Due to Hypertensive-arteriosclerotic ? vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M. D.
Address Balto City Hosps Date signed 8-26-48

correct age is especially important; if unknown, please write "unknown"

VS 1'0

G66186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G66186
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 John street
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 John street
(If rural give location)
(e) If foreign born, how long in U. S. A? NO years

3 (a) FULL NAME Charles Hechter

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 52-0348-700 219-28-7511

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary E. Hechter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1879

8. AGE: Years 68 | Months 7 | Days 27 | If less than one day: hr. 20 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired Riding Instructor

11. Industry or business

FATHER 12. Name Henry Hechter
13. Birthplace Germany

MOTHER 14. Maiden Name Lena Kreutzer
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Hechter
(b) Address 1421 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 48 26 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 3.a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Aug 25 1948, and that I last saw h im alive on Aug 25 1948.

Immediate cause of death Broncho-Pneumonia Bilateral — Duration 10 days

Due to

Due to

Other Conditions T.B. of Lt. Lung Lumbar Vertebrae (X Ray J.H.H) — 2½ yr.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Allen Deckert M.D.
Address 1114 St Paul St Date signed 8/27/48 M. D.

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61187 — Registered No. G66187 — 1216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank B. Adams (FRANK BLACKFORD ADAMS)

3 (b) If veteran, name war: WORLD WAR I

3 (c) Social Security Account No. 212-07-3255

4. Sex: m/c | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Nancy Adams

6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): July 12 1886

8. AGE: Years: 62 | Months: 1 | Days: 13 | If less than one day: hr. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual Occupation: Executive V. Pres.

11. Industry or business: Young & Selden Co

FATHER
12. Name: Frank Blackford Adams
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Caroline Blackford
15. Birthplace: West Virginia

16 (a) Informant: wife
(b) Address: Ruxton, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 27/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Henry W. Jenkins & Sons Co
(b) Address: 4905 York Road

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1948, at 1.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1948 to August 25 1948, and that I last saw him alive on August 25 1948.

Immediate cause of death: Uremia — Duration: 25 days

Due to: Chronic glomerular nephritis — Duration: 1 year +

Due to:

Other Conditions: hypertension, cardio vascular disease (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: W. F. Cox M.D.
Address: Union Memorial Hospital Date signed: 8-26-48

VS 18.

66188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Ridgefield (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM VALENTINE SJOVALL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	--	M	W	Married

6 (b) Name of husband or wife Helen Sjovall
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 11, 1896

8. AGE: Years	Months	Days	If less than one day
52	4	13	hr. min.

9. Birthplace Brooklyn, NY (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Mathias Sjovall
13. Birthplace Finland

MOTHER
14. Maiden Name Ida ?
15 Birthplace Finland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/48 (month) (day) (year)
(c) Cemetery or crematory
Location BRIDGEPORT, CONN.

18 (a) Funeral director Edgeworth Memorial
(b) Address 3911 Liberty Hgts. Ave

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Aug. 24 1948, and that I last saw him alive on Aug. 24 1948.

	Duration
Immediate cause of death Carcinoma, squamous cell, of left pyriform sinus with extension to epiglottis.	
Due to base of tongue and right vocal cord with hemorrhage.	2 yrs.
Due to Metastases to regional lymph nodes.	
Other Conditions Obstruction, laryngeal partial and esophageal partial (Include pregnancy within 3 months of death)	1 6 mos.

Date of operation due to above
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8/25/48

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G66189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G66189 Registered No.

PLEASE WRITE PLAINLY, with pen or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 COLDSPRING LANE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 COLDSPRING LANE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. EDWIN MORTIMER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband~~ wife GRACE B (BURNS)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 8 1857

8. AGE: Years	Months	Days	If less than one day
91	0	16	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name JOHN MORTIMER
FATHER 13. Birthplace MD

MOTHER 14. Maiden Name ELIZABETH
MOTHER 15. Birthplace MD

16 (a) Informant MRS GLADYS M SEBASTIAN
(b) Address 3027 HARLEM AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 27 '48 (month) (day) (year)
(c) Cemetery or crematory OLIVET
Location ST MICHAELS MD

18 (a) Funeral director Harry H Wyble
(b) Address 401 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar

Funeral Director MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 24 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 1 1946 to August 19 48 and that I last saw h~~im~~ alive on Aug 24 19 48.

Immediate cause of death Chronic Glomerular Nephritis — Duration 10 yrs
Due to Arteriosclerosis — 15 yrs
Due to
Other Conditions Rt. Inguinal Hernia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R. Kleiman M. D.
Address 3803 Edmondson Ave Date signed 8/26/48

G66190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G66190
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Powers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1882

8. AGE: Years 66 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Director of Catholic Daughters

11. Industry or business

FATHER
12. Name Thomas J. Powers
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Morris
15. Birthplace Baltimore Md

16 (a) Informant Miss Kathleen Powers, Nephew
(b) Address Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street
Huntington Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947 to Aug 25 1948 and that I last saw her alive on Aug 25 1948.

Immediate cause of death: Cardiac failure
Due to: Generalized carcinomatosis
Due to: Carcinoma of breast
Due to: None
Other Conditions: Arteriosclerotic C V Disease
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Stewart C. L. MD M.D.
Address 1 Agnes Walk Date signed 8/28/48

VS 150

Dr. Gajic
Ex 1221 Luzerne

G66191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G66191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N. Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gajic

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Gajic
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1881

8. AGE: Years 67 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Dalton ore (Town, county, and state)

10. Usual Occupation R.R. Yeteran

11. Industry or business

FATHER
12. Name Jacob Gajic
13. Birthplace Bohemia

MOTHER
14. Maiden Name Katharine Bonbup
15. Birthplace Bohemia

16 (a) Informant Ella Aleata
(b) Address 827 N. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Maryland
Location

18 (a) Funeral director Jerome Cvach
(b) Address 700 N. Chester St.

AUG 26 1948 (Date rec'd by registrar) (b) Washington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1948 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Aug 24 1948, and that I last saw h[illegible] alive on Aug 22 1948

Immediate cause of death: Coronary Artery Occlusion — Duration: [illegible]

Due to: Coronary Artery Disease — Duration: 2 yrs

Due to: Generalized Arteriosclerosis — Duration: ?

Other Conditions: Cerebral Hemorrhage. Hypertension Essential
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Legrand Bull M. D.
Address 1221 N. Luzerne Ave. Date signed Aug 25 1948

VS 150

6192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66192
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2021 Eastern Ave Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Piorunski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bronislaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kijewski
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Andrew Dubert
(b) Address 519 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (d) AUG 27 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948 at 6:50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1 47 19 to Aug 26 1948 and that I last saw h[illegible] alive on Aug 26 1948

Immediate cause of death: Coronary Thrombosis — Duration: Aug 26 48
Due to: Ch. Myocarditis — Duration: July 47
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 801 S Kenwood Ave Date signed Aug 27 1948 D.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

V 48 150

6193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G66193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 St Clement St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Parsen Robert H W. Parsen

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elsie E Parsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1900

8. AGE: Years	Months	Days	If less than one day
48	5	23	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Supply Clerk
11. Industry or business Monumental Life Ins Co

FATHER
12. Name Robert H. Parsen Sr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Kathryn Krum
15. Birthplace Balto Md

16 (a) Informant Elsie E. Parsen
(b) Address 121 St Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director A. Raul Evans
(b) Address 1420 Sc Gaton

19 (a) AUG 27 1948 (Date rec'd by Registrar) (b) Washington D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-48 19 , at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-48 19 , to 8-26-48 19 , and that I last saw h w alive on 8-26-48 19 .

Immediate cause of death	Duration
cardiac failure	
Due to myocardial storm	
Due to rheumatic heart disease & mitral stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan White M. D.
Address University Hosp. Date signed 8-26-48

VS 150

X

6194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66194
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Proctor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Proctor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Di Venti

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Joseph Di Venti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 15 1886

8. AGE: Years 62 | Months - | Days 9 | If less than one day: hr. min.

9. Birthplace: Calascibetta Italy (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

PARENTS
12. Name: Stefano Passo
13. Birthplace: Italy

RESIDENCE
14. Maiden Name: Carmela Pedalino
15 Birthplace: Italy

16 (a) Informant: Joseph H Venti (Husband)
(b) Address: 1123 Proctor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 27/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 322 S. High St.

19 (a) AUG 27 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1948, to 8/24 1948, and that I last saw h[illegible] alive on 8/24, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: Sudden
Due to: Hypertension — ?
Due to:
Other Conditions: Bronchial Asthma — In person
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify Yes or No)
(e) Means of injury

23. Signature: Joseph S. Hearn, M.D.
Address: 1115 N. Calvert St. Date signed 8/24/48

VS 150

G66195

BALTIMORE CITY HEALTH DEPARTMENT

G66195 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 E. Eager Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA MUELLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Robt. A. Mueller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1900

8. AGE: Years 48 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Norris
15. Birthplace Md.

16 (a) Informant: Robt. A. Mueller
(b) Address 5002 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3/48 (month, day, year)
(c) Cemetery or crematory U.S. Natl. Cem.
Location Balto., Md.

18 (a) Funeral director Philip Hennig Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by registrar) AUG 7 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, 10:30PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. (Medical Examiner.)
Date signed 6 Aug 48

correct age is especially important. Physicians, please

VS 151

G66196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Ellsworth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Hogg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Stephen Hogg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1864

8. AGE: Years	Months	Days	If less than one day
84	5	7	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ---- Oliver
13. Birthplace Va.

MOTHER
14. Maiden Name Mrs. Thelma Franco
15. Birthplace 2121 Ellsworth St.

16 (a) Informant Mrs. Thelma Franco
(b) Address 2121 Ellsworth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto., Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) AUG 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948, at 1:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage,
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D.
Medical Examiner.
Date signed 8-26-48

correct age is especially important. Physicians, please write

VS 151

G66197 G66137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 W. 40th St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 W. 40th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Oscar Mitchell Lemoine

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ruth Harlan
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) October 30, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	26	..... hr. ..... min.

9. Birthplace Emmerton, Va. (Town, county, and state)
10. Usual Occupation Investment Banker, senior
11. Industry or business member of

FATHER
12. Name Oscar M. Lemoine
13. Birthplace Va.

MOTHER
14. Maiden Name Maria Braxton
15 Birthplace Va.

16 (a) Informant Mrs. Ruth H. Lemoine
(b) Address 535 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave., Balto.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ..... 1948 ..... (Date filed by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Aug. 25 1948, and that I last saw him alive on Aug. 23 1948.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury .....

23. Signature John H. Janeway, M. D.
Address 1035 N. Calvert St. Date signed .....

V3 193

ES122320 G66198

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66198
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 James St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Marie Oster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Frederick J. Oster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 7, 1877

8. AGE: Years	Months	Days	If less than one day
72	7	17	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Brooks (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Rodgers (D)
15. Birthplace ?

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick T. Cole
(b) Address 1946 Pennsylvania Ave.

19 (a) (b) Tuneral Home, Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1948, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1948 to 8-24 1948, and that I last saw her alive on 8-24 1948.

Immediate cause of death Cardiac failure

Duration 4 days.

Due to Coronary occlusion probable.

Due to Coronary atherosclerosis

Other Conditions cerebral vascular accident questionable.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Guarnieri M.D.
Address Balto City Hosp Date signed 8-29-48

correct age is especially important.

VS 150

G66[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66[illegible]

555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address, 508 Riverside Road
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co.
(c) City or town Essex
(If outside city or town limits, write RURAL and give name)
(d) Street No. 508 Riverside Drive
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Dumeier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jacob Dumeier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1884

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name H. H. Sauer
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Brandau
15. Birthplace Germany

16 (a) Informant Jacob Dumeier
(b) Address 508 Riverside Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 (month) (day) (year)

(c) Cemetery or crematory Oak Haven
Location City

18 (c) Funeral director Ulrich Funeral Home
(b) Address 2004 Orleans St

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1948, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Aug 25 1948, and that I last saw her alive on Aug 25 1948.

Immediate cause of death Cancer - glandularized Carcinomatosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Strall M. D.
Address Date signed Aug 25 48

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and fully.

G66-40

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937 G66-40

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N. Robinson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. Kirtscher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Clara Kirtscher
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 24 - 1880

8. AGE: Years	Months	Days	If less than one day
67	10	26	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation City Parks
11. Industry or business General

MOTHER / FATHER
12. Name Frank Kirtscher
13. Birthplace Germany
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Clara Kirtscher
(b) Address 407 N. Robinsen

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Aug 28 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2026 Orleans St

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1948 to Aug 22 1948 and that I last saw him alive on 8-22 1948.

Immediate cause of death	Duration
myocardosis	?
Due to Hypertensive cardio vascular disease	?
Due to	
Other Conditions arteriosclerosis.	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J Gould M.D.
Address 147 E Eastern Ave Date signed 8-25-48

Correct age is especially important. Physician: please write the cause of death very plainly.

VS 150

G66201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 928

G66201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RHODA J. MASON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 13, 1869

8. AGE: Years 78 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Miss Marie Mason
(b) Address 1819 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) AUG 29 1948 (b) Carrington-Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948 at 2:45 M

21. I certify that death occurred on the date above stated, and attended deceased from June 18 1948 to Aug 24 1948 and that I last saw her alive on Aug 24 1948.

Immediate cause of death Coronary Thrombosis

Due to / Mitral Insufficiency

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
?
L

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Berlaughia M.D.
Address 1413 Druid Hill Ave Date signed Aug 26/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66202
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 McElderry St (if rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Leontine Gessford

3 (b) If veteran, name war
No

3 (c) Social Security Account No: 213-01-3954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Harry J. Gessford
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr) Sept 1, 1882

8. AGE: Years	Months	Days	If less than one day
65 66	11	25 24	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Housewife Operator
11. Industry or business Wm. Willner & Sons

FATHER
12. Name Charles L. Kidd
13. Birthplace Charleston, South Carolina

MOTHER
14. Maiden Name Lena Platt
15. Birthplace Charleston, South Carolina

16 (a) Informant Husband Mr. J. Harry Gessford
(b) Address 2310 McElderry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 AUG 27 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 August 25. 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Aug 48 19 . to 25 Aug 1948, and that I last saw her alive on 25 Aug 1948

Immediate cause of death Congestive Heart Failure — Duration 9 days

Due to Syphilitic Aortitis with Aortic Insufficiency

Due to

Other Conditions Terminal anuria with uremia — 4 days
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Permission refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald L. England M.D.
Address Maryland General Hospital Date signed 25 Aug 48

correct age is especially important. Physicians: please write the cause of death plainly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G66203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 E. 32nd. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. 32nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSABELLE MOENIUS

3 (b) If veteran, name war: No
3 (c) Social Security Account: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward Moenius
6 (c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Dec. 30, 1891
8. AGE: Years: 56 Months: 7 Days: 28 If less than one day: hr. min.
9. Birthplace: Norfolk, Va. (Town, county and state)
10. Usual Occupation: Housewife
11. Industry or business

Parents
12. Name: James W. Pennie
13. Birthplace: Baltimore, Md.

Mother
14. Maiden Name: Isabella C. Pedman
15. Birthplace: Maryland

16 (a) Informant: Mrs. Isabella Tunis
(b) Address: 2019 E. 32nd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory: Mount Carmel
Location: Baltimore

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 AUG 27 1948 (Date rec'd by registrar) (b) [illegible] Washington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 8/25 1948, and that I last saw her alive on 8/24 1948.

Immediate cause of death: Abdominal carcinoma — Duration: 6 mos.

Due to: —

Due to: — over

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Willis Guyton, M.D.
Address: 3963 Greenmount Ave. Date signed: 8/25/48

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correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G66204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3029 Mayfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Mayfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY REESE FEHLEY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-05-4932

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna C. Fehley

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 23, 1887

8. AGE: Years 31 | Months 4 3 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation watchman

11. Industry or business Bozman Bros.

FATHER
12. Name George W. Fehle
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Warner
15. Birthplace Ill.

16 (a) Informant Mrs Edna C. Fehle
(b) Address 3029 Mayfield Avenue - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Baltimore, Md,

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

AUG 27 1948 (Date rec'd by registrar) (b) [signature] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1948 to AUG 26 1948 and that I last saw him alive on Aug 26 1948

Immediate cause of death

Carcinoma urinary bladder — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 48

Findings of operation: Carcinoma bladder

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fritz J Kimzey M.D.

Address 7700 Harford Rd Date signed 8/26/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 9-1-48

6205
BF-102003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C66205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Formerly at
(d) Street No. 1148 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas B. Clary

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	M	W	Widowed

6 (b) Name of husband or wife Clara B. Clary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27-1871

8. AGE: Years	Months	Days	If less than one day
76	11	29	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business G.

FATHER
12. Name Richard Clary
13. Birthplace Maryland

MOTHER
14. Maiden Name Clementine Brashears
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 12. AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12- 1948 to 8-25-26 1948.
and that I last saw him alive on 8-25-26 1948.

Immediate cause of death	Duration
Bronchopneumonia, bilat.	
Due to Myocardial & coronary arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Dr. alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vickery M. D.
Address Balto City Hosp. Date signed 8 Aug 48

correct age is especially important. Physicians, please write

VS 139

6206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 13B

G66206 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 W Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 + 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 W Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T Fell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3rd 1898

8. AGE: Years 50 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name John Fell

13. Birthplace Md.

MOTHER 14. Maiden Name Lena Schanberger

15. Birthplace Md

16 (a) Informant Mrs. Rose V. Fell

(b) Address 1919 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St

AUG 27 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1948 at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Aug 27 1948 and that I last saw h[illegible] alive on July 1948

Immediate cause of death Pulmonary Tuberculosis — Duration 8 yrs.

Due to

Due to

Other Conditions Pulmonary Tuberculosis — 8 yrs.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence M. Lena M.D.
Address 11E Chase St Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

6207 G66207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Catherine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lawrence Riley

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-4687

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marion (Marino)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/02

8. AGE: Years	Months	Days	If less than one day
45	11	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Baltimore Transit Company

FATHER
12. Name JOHN RILEY
13. Birthplace MD

MOTHER
14. Maiden Name ELIZABETH ECKMAN
15 Birthplace MD.

16 (a) Informant MRS MARION RILEY
(b) Address 9 N. CATHERINE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 28 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Nancy A. Zeigler
(b) Address 908 Edmondson Ave

19 AUG 27 1948 (Date rec'd by Registrar) (Name) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20, 1948 to Aug. 24, 1948, and that I last saw him alive on Aug. 24, 1948

Immediate cause of death Generalized toxemia — Duration
Due to Adrenal insufficiency
Due to Generalized Exfoliative dermatitis
Other Conditions GENERALIZED EXFOLIATIVE DERMATITIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Adrenal destruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Parsons Jr. M.D.
Address St. Joseph's Hosp. Date signed 8/24/48

VS 130

3208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 666208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 N Hollins St
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie L. Travers (Mary L. Travers)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Edward W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1875

8. AGE: Years 73 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James D. Gorsuch
13. Birthplace Md

MOTHER
14. Maiden Name Sarah B. Thompson
15. Birthplace Md

16 (a) Informant Alice Whitney
(b) Address 1210 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Pitzke
(b) Address 1401 Edmondson Ave.

19 (a) AUG 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1948 to Aug 25 1948 and that I last saw h[illegible] alive on Aug 24 1948

Immediate cause of death Arteriosclerosis — Duration

Due to Stomach

Due to Marked Stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Kalaman M.D.
Address 24 N. Fremont Ave Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death plainly. Use [illegible]

VS 150

6209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 Lake Drive
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry O. Slusky

3 (b) If veteran, name war World I

3 (c) Social Security Account No. 214-03-5902

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rea Bernstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 15 1890

8. AGE: Years 58 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business

FATHER
12. Name Felix Slusky
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Selenkow
15. Birthplace Russia

16 (a) Informant Mrs. Rea Slusky
(b) Address 823 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave.

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1126 W. North Ave.

AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Aug 27 1948
and that I last saw h. A. alive on Aug 23 1948.

Immediate cause of death Hypertensive Cardio Vascular Renal

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2-3 yrs
2-3 yrs

Inmate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A A Weinstock M. D.

Address 4603 Knollcrest Date signed 8/27/48

correct age is essential for statistical purposes

666210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666210

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1112 S. Carey St. (If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Kerr

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-10-1804

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar.

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1884

8. AGE: Years	Months	Days	If less than one day
61	11	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation General Foreman

11. Industry or business B & O R.R.

FATHER 12. Name John E.

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Susan

15. Birthplace Md.

16 (a) Informant Mrs. Charles F. Kerr

(b) Address 1112 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 Edmondson ave.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 2058 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— , to — 19— ,

and that I last saw h — alive on — 19— .

Immediate cause of death — Coronary occlusion — Duration

Due to Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature David B Story M.D.

Address Univ. Hosp. Date signed 8-27-48

VS 150 Subject to Release by Medical Examiner Howard J. Mellor, M.D.

366211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 366211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Farrington Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Farrington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Silverman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Israel Gerber
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Mrs James Fink
(b) Address 3913 Farrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd or Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 27 1948 (Date received by reg.) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1948, to 8/26 1948, and that I last saw her alive on 8/26 1948.

Immediate cause of death Carcinoma of Stomach. Duration 6 mos

Due to

Due to

Other Conditions Carcinoma of Breast 5 mos
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 1115 N. Calvert St Date signed 8/31/48

VS 150

666212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 666212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4224 Kelway Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4224 Kelway Road
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSEPHINE BODGE SIBLEY

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Fem.

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced widow

6 (b) Name of husband or ~~wife~~ George L. Sibley

6 (c) If wife, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1861

8. AGE: Years 87 | Months 0 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Weymouth, Mass
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Bodge
13. Birthplace Needham, Mass.

MOTHER
14. Maiden Name Mary Chandler
15. Birthplace Boston, Mass

16 (a) Informant Mr. George N. Sibley
(b) Address 4224 Kelway Rd.

17 (a) Removal (b) Date thereof 8-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Ridgelawn
Location Watertown, Mass.

18 (a) Funeral director Wm J. Tickner & Sons.
(b) Address North & Pa. Aves.

19 (a) AUG 27 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 9 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948, to Aug 26 1948, and that I last saw h— alive on Aug. 26 1948

Immediate cause of death: Arteriosclerotic heart disease — Duration: Years.

Due to

Due to

Other Conditions Diabetes Mellitus — Years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? [illegible] at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 701 E. Preston St. Date signed 8/27/48

correct age is especially important. Physicians, please write plainly.

VS 150

937

G66213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G66213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 N. CAROLINE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 7 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N. CAROLINE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE GAINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C.

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife ALEXANDER

6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1883

8. AGE: Years 65 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace WASH. D.C. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant SINTHIA SMITH
(b) Address 1613 BARNES

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVRY
Location A.A. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1324 N. Carrollton

19 AUG 27 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1948 at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1948 to 8/25 1948 and that I last saw h[illegible] alive on 8/24/1948

Immediate cause of death

Carcinoma of Stomach — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M. D.
Address 1501 EAST MADISON ST. BALTIMORE 5, MD.
Date signed 8/27/48

VS 150

66214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 66214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Quantril Ave., Armstead
(c) Hospital or institution: Gardens

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Quantril Ave., Armstead Gard.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph AMOR KREIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	7			

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Houchens Medicine Co.

FATHER
12. Name Francis Krein
13. Birthplace Md.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Md.

16 (a) Informant Catherine M. Houchens
(b) Address 149 Northgate Rd. Northwood

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Milton Colvin
(b) Address 1349 Light St

19 (a) AUG 27 1948 (b) Huntington Williams, M.D.
(Signature of registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 10:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/25/48

correct age is especially important. Physicians, please write plainly.

666215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666215 194a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magnus B. Milner

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Rosalie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12. 1874

8. AGE: Years 73 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Jamesville Va (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER: 12. Name John B Polk Milner

13. Birthplace Va

MOTHER: 14. Maiden Name Susie Aurora

15. Birthplace Va

16 (a) Informant Thomas H. Ober

(b) Address Chesnut Hill

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem

Location Baltimore Co Md

18 (a) Funeral director Fulton & Dorsey

(b) Address 1219 Eutaw St

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert R. McFadden M.D. Medical Examiner.

Date signed 8-26-48

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666216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 666216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 McCabe Ave
(c) Hospital or institution: None 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 McCabe Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Josephine E. Hermann

3 (b) If woman, name of —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, (widowed) or divorced.
6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1871

8. AGE: Years 76 | Months 8 | Days 29 | If less than one day hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Augustus W. Deihl
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Josephine Rosenstiel
15. Birthplace Baltimore Md.

16 (a) Informant Eugene V. Hermann
(b) Address 600 McCabe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Thomson & Dietz
(b) Address 5410 E. Pratt St.

19 (a) AUG 27 1948 (b) Burial Permit for Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 August 1948 at 10:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Aug 1948 to 26 Aug 1948, and that I last saw h[illegible] alive on 25 Aug 1948.

Immediate cause of death
a Cerebral Hemorrhage — Duration 7 days
Due to Hypertension — 8 mos.
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature John Osborne M.D.
Address 560 Wendover Rd. Date signed 26 Aug 48

VS 150

Please write plainly; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66217 J1- 122377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G66217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Catherine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Mays

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 9, 1877

8. AGE: Years	Months	Days	If less than one day
71	3 4	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mays
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Martin
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Baltimore Co. Md.

18 (a) Funeral director Wilson & Son
(b) Address 1210 E. Pratt St.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1948 at 7.15 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Aug. 24 1948 to Aug. 25 1948. and that I last saw h... or alive on Aug. 25 1948.

Immediate cause of death: Peritoneal shock ? — Duration: 6 hrs

Due to Ovarian carcinoma probable.

Due to

Other Conditions Arteriosclerotic Heart disease & Phlebitis
(Include pregnancy within 3 months of death)

Date of operation 8-25-48

Major findings of operation: Paracentesis - bloody ascitic fluid.

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David N. Marcus M. D.
Address Balto City Hosp Date signed 8-26-48

VS 150

66218
1B 78395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 66218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 7-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 8 22 5yr. 8mo. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Leash

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1871

8. AGE: Years 77 (M) 77 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Leash (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Penn (D)
15. Birthplace Md.

16 (a) Informant Melva Cavalier
(b) Address 2163 Kennedy Ave
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Wilson & Lore
(b) Address 1317 E Pont St
19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Burington Williamsburg Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1942 to 8-26 1948, and that I last saw h im alive on 8-26 1948

Immediate cause of death Pulmonary edema

Due to Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions Demonlyelenteris-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Nicholas M. D.
Address Balto City Hosp Date signed 26 Aug 48

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66219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 666219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 S. Belnord ave
(If rural, give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country [redacted]

3 (a) FULL NAME Joseph Maciolek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/91

8. AGE: Years 57 | Months 5 | Days 07 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Anna —
15. Birthplace Poland

16 (a) Informant Mrs Helen Maciolek
(b) Address 815 S Belnord ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director John J Dada
(b) Address 2829 Nelson St

19 (a) AUG 27 1948 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948 at 1:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/24 1948 to 8/26 1948 and that I last saw h[illegible] alive on 8/26 1948.

Immediate cause of death Hemorrhage from liver — Duration

Due to metastatic carcinoma

Due to primary carcinoma of middle 1/3 of esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None noted above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted]
Address Maryland Hospital Date signed 8/26/48

VS 150

correct age is especially important. Physicians, please write plainly.

G66220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G66220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 Edmondson Ave.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Estelle Welty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Joseph D. Welty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1865

8. AGE: Years 82 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Spalding
13. Birthplace Md.

MOTHER: 14. Maiden Name Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Mary Zaruba
(b) Address 3420 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/48. (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Hagerstown, Md.

18 (a) Funeral director Harry H. Witzke.
(b) Address 4101 Edmondson Ave.

19 AUG 27 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26/48 19 . at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46 to 8/26 1948
and that I last saw h alive on 8/25 19 48

Immediate cause of death Acute Cardiac Failure — Duration 1 day

Due to Arteriosclerosis — 2+ Yrs

Due to Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 3629 Edmondson Date signed 8/26/48 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS 100

6221 — 666221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Ott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Bertha Ott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1865

8. AGE: Years 83 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William J. Ott
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ----------
15. Birthplace Germany

16 (a) Informant Mr. J. George Wals,
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/48 (month) (day) (year)
(c) Cemetery or crematory 1st German United Luth. Evan. Church
Location 6115 O'Donnell St.

18 (a) Funeral director Harry W. Lutz
(b) Address 4101 Edmondson Ave.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26/48. 19 . at 5.30 P.M. Army

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15/48 19 Aug. 26/48 and that I last saw him alive on Aug. 20/48.

Immediate cause of death — Duration

Chronic Cardiac Dilitation. — Unknown.

Due to

Due to — Unknown.

Other Conditions Arterio Sclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Waldschmidt M. D.

Address 233 Hanover St. Aug. 28/48.

Waldschmidt

I certify that the above is a true and correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G66222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G66222 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
House in the Pines Nursing Home 20/3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Wilhelm St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank E. Ritter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1889

8. AGE: Years 58 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. A. Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Tydings
15. Birthplace Md.

16 (a) Informant Frank E. Ritter
(b) Address 2003 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Weitzle
(b) Address 4101 Edmondson Ave.

19 (a) Date rec'd by Local Registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25/48. 19 at 2 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/15 19 48 to 8/25 19 48 and that I last saw her alive on 8/24 19 48.

Immediate cause of death Carcinoma left ovary — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert H. Katz M. D.
Address 4020 Watkins Ave. Date signed 8/27/48

Please write the causes of death clearly and correct age is especially important. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

G66223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G66223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 59 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1826 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: JOHN ROLAND STEVENS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edytha Stevens
6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1889

8. AGE: Years: 56 | Months: 9 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Rock Hall, Md. (Town, county, and state)
10. Usual Occupation: Quartermaster
11. Industry or business: Seafarer

FATHER
12. Name: John T. Stevens
13. Birthplace: Md.

MOTHER
14. Maiden Name: Emma A. Davis
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 30-48 (month) (day) (year)
(c) Cemetery or crematory: Wesley Chapel
Location: Rock Hall, Md.

18 (a) Funeral director: Edgar L Lane
(b) Address: Rock Hall Md

19 (a) [illegible] (Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1948 to Aug. 27 1948, and that I last saw him alive on Aug. 27 1948.

	Duration
Immediate cause of death: Carcinoma, bronchogenic, left upper lobe with metastases to regional lymph	
Due to: nodes, liver & kidneys	4 mos.
Due to:	
Other Conditions: Bronchiectasis, left lower lobe	Several months

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 8/27/48

V S 190

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

66224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne
(c) City or town Centreville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Clark Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 51 | Months | Days | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Henry Furbush
13. Birthplace Md

MOTHER 14. Maiden Name Annie Lucas
15. Birthplace Md

16 (a) Informant Hosp
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-48 (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill Md

18 (a) Funeral director Edgar L Lane
(b) Address Church Hill Md

19 (a) AUG 28 1948 Huntingtown Williams, Md
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1948 at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1948 to 8-27 1948 and that I last saw h.c.v. alive on 8-27 1948.

Immediate cause of death: cardiorespiratory arrest
Due to pneumonitis
Due to carcinoma of sigmoid colon
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-14-48
Major findings of operation: carcinoma of sigmoid colon
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John S. Lowery M. D.
Address University Hosp. Balto 1 Md Date signed 8-27-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G662225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Graves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-22

8. AGE: Years 26 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation Farm work

11. Industry or business

FATHER
12. Name Benton Graves
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Mary C. Morrison
15. Birthplace So Carolina

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 27 48 (month) (day) (year)
(c) Cemetery or crematory
Location Bennettsville S. C.

18 (a) Funeral director Holland Funeral Home
(b) Address 631 Laurel Hill Ave.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at 1-38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/23 1948, and that I last saw h[illegible] alive on 8/23 1948.

Immediate cause of death: Congestive heart failure. — Duration: weeks.

Due to Cardiac hypertrophy and dilitation. — months or years.

Due to Hypertension, Chr. nephritis — years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriosclerosis, hypertension, chronic interstitial nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Courtney J. Stipe M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8-25-48

VS 150

666226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 666226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Kennedy Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia A. Broomhead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Robert C. Broomhead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 6, 1858

8. AGE: Years	Months	Days	If less than one day
90	4	20	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Hammel
13. Birthplace Penna

MOTHER
14. Maiden Name Katherine Hyde
15 Birthplace Penna

16 (a) Informant Zora E. Hammel
(b) Address 1918 Kennedy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Harrisburg Cem
Location Harrisburg, Penna.

18 (a) Funeral director John O. Thoran
(b) Address 3000 E. Balt. St.

19 AUG 28 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 6.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947 to Aug 26 1948 and that I last saw h-r alive on Aug 25 1948.

Immediate cause of death: Diabetes mellitus — Duration 1 yr
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Harry Hyde M. D.
Address Date signed

V3 150

A366227 Tucker

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. A366227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos 17 da

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Rodney Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 43 Months Days If less than one day hr. min.

9. Birthplace maryland (town, county, and state)

10. Usual Occupation machine operator

11. Industry or business K & S Plumbing Co 10 Foundry St, Hagerstown

FATHER 12. Name Thomas A Tucker

13. Birthplace md

MOTHER 14. Maiden Name Martha E. Gross

15. Birthplace md.

16 (a) Informant Rita Faubl

(b) Address Keyser W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1948 (month) (day) (year)

(c) Cemetery or crematory Lutheran

Location Locust Grove Md

18 (a) Funeral director C. W. Foster Bro

(b) Address Boonsboro Md

19 (a) AUG 23 1948 (Date rec'd by Registrar) (b) Hagerstown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 1 1948 and that I last saw him alive on July 30 1948 approx.

Immediate cause of death Respiratory Failure — Duration

Due to internal hydrocephalus — 2 mos 1 wk

Due to adhesive arachnoiditis — [2 mos 1 wk

Other Conditions Influenza pneumonia — 5½ mos

Bronchial pneumonia, Bilateral

Date of operation May 11, 21, June 2, 48

Major findings of operation: Adhesive arachnoiditis

of autopsy: no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March 8, 1948 at M
(c) Where did injury occur? Hagerstown, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? K & S Plumbing Co N Foundry St (Specify) While at work? yes
(e) Means of injury arm caught in wheel

23. Signature J. R. Hankins

Address Univ Hospital Date signed 8/27 M. D.

Certified by H. J. Mullins, M.C. Death due indirectly to external causes, in that head injury was a factor

VS 190

666228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County —
(c) City or town Greencastle (If outside city or town limits, write RURAL, and give town)
(d) Street No. 122 North Allison Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Elsie Jean Lucille Mellinger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1926

8. AGE: Years 22 | Months 3 | Days 34 | If less than one day — hr. — mtn.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation clerical

11. Industry or business

FATHER
12. Name Elmer Mellinger
13. Birthplace Penna

MOTHER
14. Maiden Name Bessie M. Shatzer
15. Birthplace Penna

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 28 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Greencastle, Pa.

18 (a) Funeral director H. G. Lehmer & Sons
(b) Address Mellingtons, Baltimore, Huntington, Williamsport

19 (a) [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Aug 28 1948 and that I last saw h[illegible] alive on Aug 28 1948.

	Duration
Immediate cause of death: acute respiratory failure	30 min
Due to: bronchial constriction	30 min
Due to: drug sensitivity	
Other Conditions: recent lumbar spinal fusion	

(Include pregnancy within 3 months of death)

Date of operation 8-23-48

Major findings of operation: Ruptured P-S-D with bladder perforated d.c

See Duncan Magistre

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) [illegible]te of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Clausen

Address Union Memorial Hosp. Date signed 8/28/48 (M) (D)

VS 190

666229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183B

Registered No. 666229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eaton Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rosson Hotel, 512 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1880

8. AGE: Years 68 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Liverpool England (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Civil Engineer

FATHER 12. Name James E Hughes
13. Birthplace England

MOTHER 14. Maiden Name Martha Clements
15. Birthplace England

16 (a) Informant Phillip Hughes
(b) Address 922 E 21st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Md

18 (a) Funeral director Milton Cook Inc
(b) Address 1214 St

19 [illegible] (Date received by registrar) [illegible] for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948, to Aug 27 1948 and that I last saw h[illegible] alive on Aug 23 1948.

Immediate cause of death: Cerebral thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J Singh M. D.

Address 506 E North Ave Date signed 8-27-48

correct age is especially important. Physicians: please write plainly and use ink. Do not use pencil.

V S 150

66230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 66230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hereford Rd.
(c) Hospital or institution: Addington Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Hampden (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Clara Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced divorced

6 (b) Name of husband or wife Charles Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 30 1875

8. AGE: Years 72 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Bachman Valley Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Bachman
13. Birthplace Md

MOTHER
14. Maiden Name Susan Ann Myers
15. Birthplace Md

16 (a) Informant Mrs Mary Smith Daughter
(b) Address 2719 Hampden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Johns Luther Miller
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington H. Williams M. D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 2 30 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Aug 27 1948, and that I last saw her alive on Aug 26 1948.

Immediate cause of death	Duration
Bronchial Asthma 3	14yr
Mitral Regurgitation 2	14yr
Due to Coronary Thrombosis (1)	4yr
Due to Chronic Interstitial Nephritis	14yr.
Other Conditions Interstitial nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Williams M. D.
Address 2878 Hereford Date signed 8-27-48

correct age is especially important. Physicians please write the causes of death plainly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Foster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Fois

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1878

8. AGE: Years 70 Months 7 Days 5 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self employed

FATHER
12. Name Edwin Foster
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Cynthia Hill
15. Birthplace Md.

16 (a) Informant Mrs. Chas. E. Foster
(b) Address 2104 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Lee Howard Strong
(b) Address 3207 W. North Ave.

19 [illegible] Burlington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1948, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20, 1948, to Aug. 27, 1948, and that I last saw him alive on Aug. 26, 1948

Immediate cause of death: Circulatory failure — Duration: one week

Due to: Carcinoma of liver — 6 mo.+

Due to: Carcinoma of thyroid gland — 6 mo.+

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr. 27, 1948 Date of autopsy

Major findings of operation: Exploratory + resections of cancer of thyroid gland

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.

Address 3300 W. North Ave. Date signed 8/27/48

correct age is especially important. Physicians, please fill out this certificate carefully.

V8 150

G66232 6-20-48 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephanie Diana Scott ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/48

8. AGE: Years	Months	Days	If less than one day
		1	18 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles Scott
13. Birthplace Triangle Va

MOTHER
14. Maiden Name Lucile Thomas
15. Birthplace Baltimore

16 (a) Informant Lucile Thomas
(b) Address 427 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 28 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Chas. G. Cooper
(b) Address 513 N Carrollton Ave

[illegible] Washington Methodist [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948 to 8/27 1948.
and that I last saw h[illegible] alive on 8/27 1948.

Immediate cause of death Pneumonia ?

Due to

Due to

Other Conditions Born of Pneumonic mother
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 8-20-48 ✓

Please write in ink. Physicians: please write the cause of death clearly and legibly. Information is especially important.

666233 Butler 97

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 666233 Registered No.

correct age is especially important. Physicians: please write in ink or use typewriter.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maude Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-25-94

8. AGE: Years 54 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Gregory Scott

13. Birthplace Va

MOTHER 14. Maiden Name Sarah Morgue

15. Birthplace Va

16 (a) Informant Harry Butler

(b) Address 1604 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto Md

18 (a) Funeral director Wm A Jackson

(b) Address 916 Pennsylvania Ave Tuesday for Williamsport, Md

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1948 to 8-25-1948, and that I last saw h alive on 8-25 1948.

Immediate cause of death Hypostatic pneumonia

Due to Pulmonary congestion + edema

Due to

Other Conditions Arteriosclerosis generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Bigelow Resident Hosp

Address Date signed 8-26-48

VS 130

111c

66234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C66234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14+

(d) Length of stay in hospital or inst. (yrs., mos., or days) 94 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707-W. Mosher
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Herman Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mrs. Mary A. Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1876

8. AGE: Years 72 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Daniel Dorsey
13. Birthplace Md.

MOTHER 14. Maiden Name Emmeline Thomas
15. Birthplace Md.

16 (a) Informant Mrs. Charles Dorsey
(b) Address 707 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pennsylvania Ave.

19 AUG 28 1948 (Date rec'd by registrar) By [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21- 1948 to 8-26- 1948, and that I last saw h[illegible] alive on 8-26- 1948

Immediate cause of death Pulmonary edema

Due to Cardiovascular renal heart disease

Due to

Other Conditions Prostatic neoplasm

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-21-48 at ? M
(c) Where did injury occur? 707 W. Mosher St. Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work? no
(e) Means of injury [illegible]

23. Signature [illegible]
Address [illegible] Date signed 8/27/48

Howard J. Mc[illegible], M.D.

correct age is especially important. Physicians: please write the cause of death clearly

66235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lyeneer Parker
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-14-[illegible]34

4. Sex: Male
5. Color or race: N
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 5, 1904
8. AGE: Years 43 | Months 11 | Days 19 | If less than one day hr. min.
9. Birthplace Williamsburg, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Parker
13. Birthplace Williamsburg, Va

MOTHER
14. Maiden Name Elizabeth Cook
15. Birthplace Williamsburg, Va

16 (a) Informant Frank C. Roberts
(b) Address 1011 N. 43rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George W. Holland
(b) Address 1631 Druid Hill Ave.

19 AUG 23 1948 (Date received by registrar) (b) Burlington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-48 19 . at 7 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 8-24 1948, and that I last saw h. alive on 8-24 1948.

Immediate cause of death (a) Malignant Hypertension — Duration 6 mos-1yr.
(b) Cardiac Hypertrophy
(c) Chronic Passive Cong.-Liv.
Due to (d) Pulmonary edema Cong.-C adherens pleuritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon H. Carter, J.F.
Address Provident Hosp. Date signed 8/25/48

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G66236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 N. Appleton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N. Appleton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOTTIE EMORY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Zebbie D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	16	hr. min.

9. Birthplace Baltimore, Maryland,
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Dorsey
13. Birthplace Maryland.

MOTHER
14. Maiden Name Emma Stewart
15. Birthplace Maryland.

16 (a) Informant Zebbie D. Emory
(b) Address 1713 N. Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 2 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1948 to Aug 25 1948, and that I last saw her alive on Aug 25 1948

Immediate cause of death Uremia — Duration 2 days

Due to Chr. Glomerular Nephritis — Duration undet.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Russell M. D.
Address 902 W. Franklin Date signed 8-27-48

VS 193

G666237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

471

Registered No. G666237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Springfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henderson Wike

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/85

8. AGE: Years 63 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Self

FATHER
12. Name: Harry Wike
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Juzetta Weaver
15. Birthplace: Penna.

16 (a) Informant: Mrs Florence D. Wike
(b) Address: 713 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Grove
Location: Petersburg Penna

18 (a) Funeral director: John A Moran
(b) Address: 300 E. Balt. St.

19 (a) AUG 28 (Date rec'd by registrar) Transcription: H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 24, 1948 to August 27 1948, and that I last saw him alive on Aug. 27, 1948.

Immediate cause of death: Carcinoma of lung with metastasis to medistinum and liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca of lung with metastasis to liver

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Peyson Jr. M. D.
Address 2 N. Gaylord St. Date signed 8/27/48

V8. 150

66238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66238

§ 3a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp, Balto, md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside corporate limits, write RURAL, and also town)
(d) Street No. 4103 Old Frederick Rd. Blessed Sacrament Church (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend James A. O'Connell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 19, 1873

8. AGE: Years 75 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER 12. Name Charles O'Connell
13. Birthplace Canada

MOTHER 14. Maiden Name Mary Ellen O'Connell
15. Birthplace Canada

16 (a) Informant Father Healy HEALY
(b) Address Blessed Sac. Church, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore St.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-48 19 , at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 19 48 to 8-25 19 48 and that I last saw h. alive on 8-25 19 48.

Immediate cause of death Pneumonia — Duration 5 days

Due to

Due to

Other Conditions Generalized Arteriosclerosis — Benign Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rev. Connell, Jr. M. D.
Address Mercy Hosp Date signed 8-25-48

VS 150

Approved by Medical Examiners office

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 6662239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: D.O.A. BALTIMORE CITY HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Mure Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Marie Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years | Months 2Mos. | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hess
13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Edelmann
15. Birthplace Maryland

16 (a) Informant James F. Hess
(b) Address 2633 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt St.

19 (a) Filed 8-28-48 (b) Remington Baltimore Md (Registrar)

per: [illegible]
VS 152 John R. Davis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948, at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw h alive on 19 .

Immediate cause of death Congenital Heart disease

Duration

Due to

Due to

Other Conditions Mongolism
Clint
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 8/27/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. H Kemplel M. D.
Address Baltimore City Hospitals Date signed 8/27/48

G66240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-5
(c) Hospital or institution: SOUTH BALTIMORE GENERAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 CHRISTOPHER AVE. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Coe, Oscar L.
3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-10-7607

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: CARRIE COE
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) MAY 11, 1880
8. AGE: Years 68 | Months 3 | Days 16 | If less than one day ..... hr. ..... min.
9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation UTILITY MAN
11. Industry or business WESTERN MD. DAIRY

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant CARRIE COE
(b) Address 3004 CHRISTOPHER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT CEM.
Location E. NORTH AVE.

18 (a) Funeral director Earl A. Kilmain
(b) Address 6867 HARFORD AVE

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Filed Aug 30 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1948 at 10:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26-1948 to 8-27-1948, and that I last saw him alive on 8-27-1948

Immediate cause of death: Coronary artery disease with infarction — Duration .....
Due to .....
Due to .....
Other Conditions: Hypertensive cardiovascular disease
Cardiac decompensation
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury .....

23. Signature William A. Harvey M. D.
Address South Baltimore Gen Hosp Date signed 8-27-48

VS 150

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and plainly.

G66241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G66241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Elgin ave., Baltimore 16, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE REBECCA BONN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20, 1868

8. AGE: Years 79 | Months 9 | Days 7 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None (Used to be school teacher)

11. Industry or business —

FATHER 12. Name ANTHONY S. BONN

13. Birthplace Maryland (Baltimore)

MOTHER 14. Maiden Name MARTHA [redacted] EWIN

15. Birthplace West Virginia

16 (a) Informant MRS. WILLIAM EWIN BONN

(b) Address 506 Amelia Rd., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1948, to Aug. 27, 1948, and that I last saw her alive on Aug. 27, 1948.

Immediate cause of death Circulatory collapse — Duration 4 days

Due to Myocardial infarction — Duration 7 yrs.

Due to Hypertensive arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Benson, Jr. M. D.

Address 101 E. 33d St. Date signed 8-27-48

VS 159

G66242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 462 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 462 E. Federal st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Rachel A. Bond

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jno. W. Bond

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1882

8. AGE: Years 66 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Harford co. Md (Town, county and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Eliza Giles
15. Birthplace Harford co. Md.

16 (a) Informant Mrs Merritta Stewart
(b) Address 3110 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/48 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md.

18 (a) Funeral director William Chapman
(b) Address 1701 McCulloh St.

19 AUG 28 1948 (Registrar) Evelyn Williams (Deputy Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 8/26 1948 and that I last saw h[illegible] alive on 8/25 1948

Immediate cause of death cerebral hemorrhage — Duration 7 days

Due to hypertensive cardio-vascular-renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1500 EAST MADISON ST. BALTIMORE 5, MD.
Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death plainly.

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G66243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110 B

Registered No. G66243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 Spring Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sylvia Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1881

8. AGE: Years 68 | Months - | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Augusta Ga.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Gibson
13. Birthplace Ga.

MOTHER
14. Maiden Name Katie ?
15 Birthplace Ga.

16 (a) Informant Katie Ollie Frazier
(b) Address 207 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mo. Roth & Ellicott or Dept
(b) Address 1129 N. Carlins St

19 (a) Aug 28 1948 (b) Lexington Funeral Home, Inc. Registered by

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-1948 at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1948 to 8-24 1948 and that I last saw him alive on 8/24 1948

Immediate cause of death: Bronchio Pneumonia 10 days
& Pleurisy 7 days
Due to Exposure
Due to Cold

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) while at work?
(e) Means of injury

23. Signature Jas. R. Blake M.D.
Address 1603 N. Carlins Date signed 8/27

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66244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G66244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Linden Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Barbara Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife ROBERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 21, 1921

8. AGE: Years 27 | Months 0 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace MICHIGAN
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name CHARLES CHARTIER
13. Birthplace MICHIGAN

MOTHER
14. Maiden Name LOIS
15. Birthplace MICHIGAN

16 (a) Informant ROBERT MARTIN
(b) Address 1510 LINDEN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 30 '48 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location FREDERICK AVE

18 (a) Funeral director Nam H Wells
(b) Address 4101 Edmondson Ave

19 AUG 28 1948 (Date rec'd by Registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-48 19.. at 1 12 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull - Intracranial Hemorrhage

Due to .....

Other Conditions Hospital Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-48 at 12 20 P.M.
(b) Where did injury occur? 1510 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Outside 1510 Linden Ave While at work? No
(d) Means of injury Jumped Out Window

23. Signature Robert B. McFadden M.D.
Medical Examiner.

Date signed 8-27-48

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66245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115C

Registered No. G66245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 W Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MASTER WAYNE LEE BRUCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1937

8. AGE: Years	Months	Days	If less than one day hr.	min.
10	11	2		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gifford Bruce
13. Birthplace Md.

MOTHER 14. Maiden Name Frieda Sadofsky
15. Birthplace Md

16 (a) Informant Mr. Gifford Bruce
(b) Address 1937 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/48 (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Ednor Md

18 (a) Funeral director Henry A. Wittstadt
(b) Address 410 Edmondson Ave

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Signature for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 2 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948, to 8/27 1948, and that I last saw him alive on 8/27 1948.

Immediate cause of death Hemorrhage (Shock) — Duration

Due to Post. operative tonsillectomy

Due to

Other Conditions Pneumatic fever
(Include pregnancy within 3 months of death)

Date of operation 8/26/48

Major findings of operations Hypertrophied tonsillitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph R. Liberto M. D.
Address Bon Secours Hosp Date signed 8/27/48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G666246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. CAREY ST
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 HOLLINS ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARION L STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 23, 1898

8. AGE: Years	Months	Days	If less than one day
50	1	27	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name CHARLES STEWART

13. Birthplace MD

MOTHER 14. Maiden Name SARAH NEWLIN

15. Birthplace MD

16 (a) Informant MR THEODORE STEWART

(b) Address 1302 HOLLINS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 30 '48 (month) (day) (year)

(c) Cemetery or crematory UKRAINE PK

Location 3801 FREDERICK AVE

18 (a) Funeral director [illegible]

(b) Address 4101 [illegible]

19 AUG 28 1948 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 26 1948 at 4:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1948 to Aug 26 1948 and that I last saw him alive on Aug 26 1948

Immediate cause of death Generalized Carcinomatosis — Duration 3 Mos.

Due to Carcinoma Rt. Breast — Duration unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Cammarello M. D.

Address 910 W. Lanvale St Date signed Aug. 24-1948.

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correct age is especially important. Punctuation, spelling, and abbreviations should be avoided.

66247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

✓ G66247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(c) State Md. (b) County
(a) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Argyle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-6594

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) -·-1893
8. AGE: Years 55 Months Days If less than one day hr. min.
9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business
12. Name ?
13. Birthplace S. C.
14. Maiden Name
15. Birthplace S. C.
16 (a) Informant Sarah Nickens
(b) Address 1105 Argyle Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director E. Halstead
(b) Address 914 Penna Ave
19 (a) AUG 28 1948 (Date rec'd by registrar) Thomas for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 3.20a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed August 23, 1948

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X

66248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 23-1 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Peach Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENSE CHASE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2/1882

8. AGE: Years 67 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name [redacted] ? Philip Chase
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Calvert Co. Md.

16 (a) Informant Ethel Brown
(b) Address 1015 Peach Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) 8 29 48

(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto.

18 (a) Funeral director Walter B. Sanders
(b) Address 139 W. Hamburg St.

19 (a) AUG 28 1948 (Date received by registrar) (b) Cremation or Burial Permit No.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 1:55 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 8/25/48

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G66249 BC-48-18583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

V G66249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs 45"
(e) Length of stay in Baltimore (yrs., mos., or days) 2hr 45"

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
9 City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Stone Wood Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl VON PARIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 25/48

8. AGE: Years | Months | Days | If less than one day: 2 hr. 45 min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name BONAVENTURE VON PARIS
13. Birthplace BALTIMORE

MOTHER 14. Maiden Name BERNICE CHEESUM
15 Birthplace Pa.

16 (a) Informant Bonaventure Von Paris
(b) Address 1522 Stonewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Herman Mill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 AUG 28 1948 (Date received by registrar) (b) Huntington Millname Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 25 1948 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 25 1948 to AUG 25 1948, and that I last saw h CA alive on AUG 25 1948.

Immediate cause of death: Cardio Resp failure — Duration: 2 hrs.
Due to: Prematurity
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Aponte M.D.
Address Mercy Hosp Date signed 8/

X

VS 150

66250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G66250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) H.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Eburg

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Estella F Eburg
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Mar 27-1869

8. AGE: Years	Months	Days	If less than one day
79	5	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

MOTHER / FATHER
12. Name Henry Eburg
13. Birthplace Md
14. Maiden Name Mary Sinkel
15. Birthplace Md

16 (a) Informant Maurice Eburg
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 30/48 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) (Date received by registrar) (b) Signature for Williams, D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 28 1948 and that I last saw h alive on Aug 27 1948.

Immediate cause of death Aspiration of saliva — Duration

Due to generalized debility

Due to Cardiac & renal failure

Other Conditions Decubitus
(Include pregnancy within 3 months of death) Intertrochanteric fracture left femur

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-20-48 at , M
(c) Where did injury occur? Hampstead, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fall out of bed

23. Signature R. C. Hunter, M.D.
Address University Hospital Date signed 8-28-48
Homer G. Williams, M.D. 108

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666251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. 666251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Edgewater
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-26-3402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 8, 1930

8. AGE: Years	Months	Days	If less than one day
17	11	19	hr. min.

9. Birthplace Phila., PA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JAMES M. FRANKLIN
13. Birthplace CHURCHTON, MD

MOTHER
14. Maiden Name FANNIE CROUCH
15. Birthplace CHASE, MD.

16 (a) Informant JAMES M. FRANKLIN
(b) Address CHURCHTON, MD.

17 (a) BURIAL (b) Date thereof Aug. 30, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. JAMES
Location TRACEY'S, MD.

18 (a) Funeral director J. A. Hardesty & Son
(b) Address Galesville, Md

AUG 29 1948
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 4 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 8/27 1948, and that I last saw her alive on 8/27 1948.

Immediate cause of death: Acute Yellow Atrophy — Duration

Due to: Cirrhosis & Ileus

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hepatomegaly + splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Benson M.D.
M. D.

Address Un. Hospital Date signed 8/27/48

G66252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G66252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Del~~ Md (b) County Cecil
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bennett Broaddus

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
	None	Male	Colored	

6 (b) Name of husband or wife Stella
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 12-25-90

8. AGE: Years	Months	Days	If less than one day
57	8	2	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name	Andrew Broaddus
13. Birthplace	Va.
MOTHER 14. Maiden name	Sallie Washington
15. Birthplace	Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 31, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cecilton
Location Cecilton Md
(a) Funeral director Edward Fellows
(b) Address Middletown Md

8-29-1948 (Date rec'd by registrar) (b) (Signature of registrar)

MEDICAL CERTIFICATION 24 hr

20. DATE OF DEATH August 27 1948 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1948 to 8/27 1948 and that I last saw h alive on 8/27/1948.

Immediate cause of death: Mediastinitis and secondary Empyema pulmonalis
Due to: Removal of cancer of L. Stomach and Esophagus
Due to:
Other Conditions: Anemia
(Include pregnancy within 3 months of death)
Date of operation 8
Major findings of operation: Ca. of Stomach & Esophagus
of autopsy:

Duration
5 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas A. Gehan
Address JOHNS HOPKINS HOSPITAL Date signed 8/27/48

VS 150

666253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

666253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N Collington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 405 N Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Brafman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Amelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 18 1869

8. AGE: Years	Months	Days	If less than one day
79	7	9	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Solomon Brafman
13. Birthplace Germany

MOTHER
14. Maiden Name
15 Birthplace Germany

16 (a) Informant Sol Brafman
(b) Address 2047 Ruxton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Ohel Yakov Cong
Location Herring Run

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W. North Ave.

(a) Aug 29 1948 (Date received by registrar)
(b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Aug 24 1948, and that I last saw h[illegible] alive on Aug 24 1948.

Immediate cause of death: Cardiac failure — Duration: 2 months
Due to: Cardio Vascular
Due to: Senility — 2
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. J. Sullivan M. D.
Address 100 N Mullin Date signed 8/28/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66254 ✓ G66254 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Esplanade Apt. 7BB
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplande apts 7 B B
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. Lewis Emanuel Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	white	Widower

6 (b) Name of husband or wife Marie Salaves

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	11	17		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Emanuel Hess
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Rosenstock
15. Birthplace Baltimore, Md.

16 (a) Informant Lewis Hess
(b) Address 618 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave
(Signature of registrar) Registrar

AUG 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug 28 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Donald Jandorf M. D.
Address 1077 Hanford Rd Date signed 8-28-48

VS 150

R. Donald Jandorf

Physician: please write the cause of death clearly and legibly. Correct age is especially important.

666255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1643

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Park Heights Ave. Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Rubinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Joseph Rubinstein
(b) Address 2616 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetary
Location Rodgers Ave

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

AUG 29 1948 (Date rec'd by registrar) Remaining to Washington

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1948. to Aug. 28 1948, and that I last saw h alive on Aug 27 1948.

Immediate cause of death cardiac failure — Duration

Due to Arteriosclerotic heart disease — 10 yrs.

Due to Coronary sclerosis

Other Conditions Urinary tract infection, Chronic bronchitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Burgin M. D.
Address 6721 Reisterstown Rd Date signed Aug. 28 1948

VS 199

X

G66256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G66256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 Norfolk Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Norfolk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age 187 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, (1871)

8. AGE: Years 77 | Months - | Days 2 | If less than one day/ hr. min.

9. birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Joseph Fink
13. Birthplace Poland

MOTHER
14. Maiden Name Jennie ?
15 Birthplace Poland

16 (a) Informant Bessie Fink
(b) Address 2902 Norfolk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 29- 48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cong.
Location Southern Avenue

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Ave.

AUG 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27, 1948, at 12:1[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Aug 1948.
and that I last saw h[illegible] alive on Aug 27 1948.

Immediate cause of death Heart Failure — Duration ?
Due to Arteriosclerosis — Duration ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Lisansky M. D.
Address 320 Liberty Hgts Ave Date signed

VS 193

G66257

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66257
Registered No.

CERTIFICATE OF DEATH 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Rosenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Heinrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name of father Isaac

13. Birthplace Germany

14. Maiden Name of mother Flora

15. Birthplace Germany

16 (a) Informant George Salomon

(b) Address 2360 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Belair Road

18 (a) Funeral director Lee Lewis Inc

(b) Address 2400 Eutaw Place

19 (a) Registrar [illegible] (b) Date received [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1948, at 10:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948 to Aug 27 1948, and that I last saw h[illegible] alive on Aug 27 1948.

Immediate cause of death Acute Leukemia
Bronchopneumonia

Due to

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Koh

Address Sinai Hosp. Date signed 8/27/48 M. D.

Correct age is especially important. Physician, please write plainly.

666258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69

Registered No. 666258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1758 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Lee Mayer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/5/71

8. AGE: Years 76 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation druggist

11. Industry or business

FATHER 12. Name Lee

13. Birthplace Germany

MOTHER 14. Maiden Name Rosa Ricef

15. Birthplace Germany

16 (a) Informant Wm J Schnitta Jr

(b) Address 1644 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)

(c) Cemetery or crematory Beth Sholom

Location Donell St

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

AUG 29 1948

(Registered by registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948, at 6 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/31 1948 to 8/26 1948, and that I last saw him alive on 8/26 1948.

Immediate cause of death Cardiac failure — Duration

Due to Cirrhosis alcoholic
Heart Disease

Due to

Other conditions Pellagra
Carbon Monoxide
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas J Blank M. D.
Address Maryland General Date signed

VS 150

931

666259

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666259
Registered No.

CERTIFICATE OF DEATH 61

666259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3438 Piedmont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 Piedmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jaskind
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired
11. Industry or business

FATHER 12. Name not known
13. Birthplace Russia

MOTHER 14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Sonia Jaskind
(b) Address 3438 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Loredale
Location Pulaski Hwy & Hamilton Ave

18 (a) Funeral director Jack Lewy One
(b) Address 2402 Eutaw Place

19 (a) 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to Aug 28 1948
and that I last saw him alive on Aug 27 1948

Immediate cause of death Coronary thrombosis — Duration 3 days
Due to Coronary artery disease — 6 years
Due to Arterio-sclerosis & diabetes — 10 years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 8/28/48

VS 150

666260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666260

157 g

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lenan
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Adler Drive Alden
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

12. Name William Lewis
13. Birthplace New York

14. Maiden Name Shirley T. Illous
15. Birthplace Westvirginia

16 (a) Informant William Lewis
(b) Address 10 Adler Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1426 Eutaw Place

AUG 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 4 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Aug 27 1948 and that I last saw him alive on Aug 27 1948

Immediate cause of death	Duration
aspiration Pneumonia	
Due to Blood from Upper Respiratory Tract	
Due to Unknown reason	
Other Conditions Mongolism Atresia 12 and part of Duodenum	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pneumonia Aspiration Atresia of part of Duodenum

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney A. Weston M. D.
Address Lenan Hospital Date signed Aug 29/48

VS 150

666261

AB-10150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93

Registered No. 666261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Normal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Koenig

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8th 1881

8. AGE: Years	Months	Days	If less than one day
67	7	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Koenig
13. Birthplace Hungary

MOTHER
14. Maiden Name Frances Fisher
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto City Md.

18 (a) Funeral director Tasaduck Funeral Home
(b) Address 7401 Belair Rd

AUG 29 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27- 1948, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25- 1935 to 8-27- 1948, and that I last saw him alive on 8-27- 1948.

Immediate cause of death Pulmonary edema.
Due to Arteriosclerotic Cardio-vascular Disease
Due to
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kuhen, M.D.
Address Balto City Hosp. Date signed 31 Aug 48.

VS 110

SC-[illegible]-1829

666262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Jessups (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Vincent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-48

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER / FATHER

12. Name Richard

13. Birthplace Md.

14. Maiden Name Catherine Albers

15. Birthplace Md.

16 (a) Informant Richard Vincent

(b) Address Jessups, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Glenwood Meth.

Location Balto. Co. Md.

18 (a) Funeral director Cassidy Funeral Home

(b) 7401 Belair Rd.

19 (a) AUG 29 1948 (Date rec'd by registrar) Arlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1948 to 8-28 1948.
and that I last saw h[illegible] alive on 8-28 1948.

Immediate cause of death Acute Toxemia — Duration

Due to Diffuse peritonitis

Due to Congenital volvulus of terminal ileum (Meckel's diverticulum)

Other Conditions (Include pregnancy within 3 months of death)

Date of operation 8/28/48

Major findings of operation: Congenital volvulus terminal ileum

of autopsy: Same as above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter J. Bernard M. D.

Address St. Agnes' Hosp. Date signed 8/28/48

VS 150

G66263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66263
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital St. Joseph's 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 851 Wellington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife James Wilson
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1867

8. AGE: Years	Months	Days	If less than one day
81.	—	25	hr. min.

9. Birthplace Baltimore Co. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas B. Cole
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Cole
15. Birthplace Maryland

16 (a) Informant Milton F. Cole
(b) Address 27 East 21st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Aug 30 1948 (b) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948, at 3:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 11, 1948 to Aug. 26, 1948, and that I last saw her alive on Aug. 26, 1948.

Immediate cause of death	Duration
Cerebral-Vascular Accident	
Due to Generalized Arteriosclerosis	
Due to Arteriosclerotic Heart Disease	
Other Conditions Cardiac Decompensation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Pinegar Jr.
Address St. Joseph's Hosp. Date signed 8/29/48

G66264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66264 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 ARLINGTON AVE.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 ARLINGTON AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA ELIZABETH VICKERS.

3 (b) If veteran, name war —
3 (c) Social Security Account No. NONE.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ROBERT E. VICKERS
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) FEB. 2, 1874
8. AGE: Years 74 | Months 6 | Days 8 | If less than one day: hr. min.
9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business —

FATHER
12. Name JOSEPH G. BISSER
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name LENA BENNETT
15. Birthplace BALTIMORE, MD.

16 (a) Informant HUSBAND (ROBT. E. VICKERS)
(b) Address 2406 ARLINGTON AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland
18 (a) Funeral director Geo. H. Reynolds
(b) Address [illegible]
(Deputy registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 28, 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 14 1948 to AUG 28 1948 and that I last saw HER alive on AUG. 28 1948.

	Duration
Immediate cause of death: ACUTE CARDIAC DECOMPENSATION	2 WEEKS
Due to: ARTERIOSCLEROTIC CVDis.	2 YRS.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation NONE.
Major findings of operation:
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur Karfgin M. D.
Address 4230 LOCH RAVEN BLVD. Date signed 8-28-48

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 1150

G66265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G66265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or institution St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Carroll
(c) City or town Rural Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Scheller, Mrs. Effie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	

6 (b) Name of husband or wife William
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) Jan. 13, 1886

8. AGE: Years	Months	Days	If less than one day
62	7	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name George Gartrell
13. Birthplace Md

MOTHER
14. Maiden Name Antonine
15 Birthplace

16 (a) Informant Lon C. Scheller
(b) Address Mt. Airy Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Prospect
Location Mt. Airy Fred. Co. Md

18 (a) Funeral director E. M. Waltz
(b) Address Winfield, Md

19 (a) Filed [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948 at 2:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1948 to Aug. 29, 1948, and that I last saw her alive on Aug. 29, 1948

Immediate cause of death Liver failure — Duration 1 wk.
Due to Cirrhosis of the liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 8-24-48
Major findings of operation: Large liver
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Joseph Krejci M.D.
Address 1400 N. Caroline St. Date signed 8-29-48

VS 180

666266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Rest Nursing Home 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLORA S. DAVIS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 21, 1865

8. AGE: Years: 83 | Months: 4 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Highland Co. Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Frank Floyd
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Page
15. Birthplace: Virginia

16 (a) Informant: Mrs. Ruth Zinn
(b) Address: 931 Montpelier Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. (month) (day) 1948 (year)
(c) Cemetery or crematory: Odd Fellows
Location: Salem, W. Va.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street
(c) Date received by registrar: Aug 29 1948 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1948, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948, to Aug 28 1948, and that I last saw her alive on Aug 27 1948

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 10 yrs
Due to: Congestive Failure — 1 week
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Leonard Wallenstein M. D.
Address: 898 N 3 St. Date signed: 8/28/48

VS 150

G66267

223701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

G66267
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 S. Broadway, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Parkes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-27-77

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	0	1		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Turner
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Burnett
15. Birthplace Md.

16 (a) Informant Della Johnson-935 S. Paca St
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Abingdon M.E. Church
Location Harford Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 427 St. Paul St.

19 AUG 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-28- 1948 at 3: A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-[illegible]-48 1948. to 8-27- 1948.
and that I last saw her alive on 8-27- 1948.

Immediate cause of death	Duration
(a) Carcinoma of Kidney, Pelvis, Ureter	10 months
(b) Metastasis to liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1948
Major findings of operation: Carcinoma of R. Kidney
of autopsy: not permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Mason C. Andrews M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8-27-48

VS 150

G66268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

666268 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Wilkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. MERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Margaret Merson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 14th 1884

8. AGE: Years 64 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Building

FATHER
12. Name: Thomas Merson
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Oswald Merson
(b) Address: Ft. Pleasant, A.A.Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month, day, year)
(c) Cemetery ~~or crematory~~: Cedar Hill
Location: Balto. Md.

18 (a) Funeral director: Williams Cook Inc.
(b) Address: 1217 St. Paul St.

AUG 29 1948 (Date rec'd by registrar) (b) Huntington Williamsburg Mass

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident prob. ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of spinal cord.
Edema of lungs.
and Arteriosclerotic cardiovascular disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 25 at 20:3 M.
(b) Where did injury occur? Above address
(d) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: fall down steps (inside)

23. Signature: George H. Merrill M.D.
Medical Examiner.
Date signed 8/24/48

VS 151

G66269

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66269 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Nottingham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Nottingham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter A Tassos

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1884

8. AGE: Years 58 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Athanasios Tassos
13. Birthplace Turkey

MOTHER
14. Maiden Name Evgenia
15. Birthplace In Turkey

16 (a) Informant Mrs Marie M Tassos
(b) Address 604 Nottingham Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 30 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co Md

18 (a) Funeral director Mellon & Lee
(b) Address 1219 E Fayette St

19 (a) Aug 30 1948 (Sale rec'd by registrar) (b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948 at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to 8/26 1948
and that I last saw h/m alive on 8/26 1948

Immediate cause of death	Duration
Cerebral hemorrhage	8/26/48
Due to Hypertensive cardio vascular Disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3629 Edmondson Date signed 8/27/48 M. D.

V S 150

correct age is especially important. If uncertain, please write

X

G66270
M. - 122075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. G66270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5519 Summerfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine S Northling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Lawrence C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 29, 1887 ?

8. AGE: Years	Months	Days	If less than one day
61 ?	2	29	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.
18 (a) Funeral director Wm Cook Inc.
(b) Address 127 St. Paul St.

AUG 29 1948 [illegible]
(Date rec'd by registrar)

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1948 at 1.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Aug. 27 1948, and that I last saw h er alive on Aug. 27 1948.

Immediate cause of death	Duration
(a) Respiratory failure	
Due to (b) Brain Tumor, Cystectomy, Treatment, Left frontal	
Due to (c)	
Other Conditions Pulmonary Embolism & Syncope	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed M. D.

G66271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 75c

G66271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Yolanda Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gerard.

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 15, 1943

8. AGE:	Years	Months	Days	If less than one day
	5	6	12	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilbert E. Gerard
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Veath
15. Birthplace Baltimore

16 (a) Informant Wilbert E. Gerard.
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1818 Light St.

19 AUG 29 1948 Washington Millicent, M.D.
(Date rec'd by registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1948 to Aug. 27 1948 and that I last saw him alive on Aug 27, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 11 hrs

Due to Aplastic Anemia

Due to

Other Conditions Generalized Lymphadenopathy.
(Include pregnancy within 3 months of death)

Date of operation Splenectomy July 31, 1948

Major findings of operation:

of autopsy: Generalized lymphadenopathy - blood stream, sternal marrow, spleen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence /at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Enos
Address Mercy Hosp. Date signed 8/27/48

G66272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

G66272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins ave.
(c) Hospital or institution St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith V. Rosenberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 7, 1884

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Elijah A. Dorsey
13. Birthplace Md

MOTHER 14. Maiden Name Sarah V. Grimes
15. Birthplace Md

16 (a) Informant Mrs. Philip Bauman
(b) Address 2145 S. Augusta ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

19 (a) Date rec'd by Registrar AUG 29 1948 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18/ 1948, to 8/27/ 1948, and that I last saw her alive on 8/21/ 1948.

Immediate cause of death Cardio respiratory failure. — Duration 2.

Due to Hepatic insufficiency — 1 month 2 days.

Due to Cholelithiasis.

Other Conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation August 25, 1948

Major findings of operation Bilirubin Chromia - stone in common duct — CHROMOSIS

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. Sherwin M. D.

Address Hospital Date signed 8-27-48

Baltimore 29, Md.

66623 32-48-1230 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 66623

CERTIFICATE OF DEATH 111a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Howard Ave #1 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilmer Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/18/08

8. AGE: Years | Months | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Wilmer Smith
13. Birthplace BALTIMORE

MOTHER 14. Maiden Name MARY Davis
15. Birthplace W. Virginia

16 (a) Informant
(b) Address

17 (a) Aug 30/48 (Buried, cremation, or removal) (b) Date thereof Aug 29/48 (month) (day) (year)
(c) Cemetery or crematory New Cath. Location Edmondson Ave

18 (a) Funeral director M. N. Armacost
(b) Address 4204 Ridgewood Rd

Aug 29 1948 Hampton Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Aug 27 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death Pulmonary Embolus — Duration

Due to Dehydration & Acidosis

Due to Vomiting

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Avante
Address Mercy Hosp Date signed 8/28

VS 150

G66274 Pokomoke G66274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Walbrook (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Phoenix Foulson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-1874

8. AGE: Years 74 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER 12. Name Benj Wallis
13. Birthplace Md

MOTHER 14. Maiden Name Mary Jarrell
15. Birthplace Md

16 (a) Informant Daughter
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Sylvestria Cem
Location Pikesville Balt Co.

18 (a) Funeral director Edward Poulson
(b) Address 2317 W Baltimore St Baltimore Md

19 (a) 8-29 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1948 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-27 1948 and that I last saw her alive on 8-27 1948

Immediate cause of death (a) Metastatic C. Ca.
Due to Sarcoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: (a) ora

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Root M. D.
Address Church Home Hosp Date signed 8-27-48

VS 150

X

G66275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G66275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SOUTH BALTO. GEN.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6614 O'DONNELL ST.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country NATURALIZED

3. (a) FULL NAME Mincsik, Sr. Joseph
3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-26-3567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	MARRIED

6 (b) Name of husband or wife MARTHA
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT. 3, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	24	hr. min.

9. Birthplace YIRENA - CZECHO - SLOVAKIA (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business FOOD STORE

FATHER
12. Name JOHN MINCSIK
13. Birthplace CZECHO - SLOVAKIA

MOTHER
14. Maiden Name SALUNIK (?)
15. Birthplace CZECHO SLOVAKIA

16 (a) Informant MARTHA MINCSIK (WIFE)
(b) Address 6614 O'DONNELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory ST. ANDREWS RUSSIAN
Location OLD GERMANTOWN RD. BALTO. CO.

18 (a) Funeral director Wells Byrnes Bradley
(b) Address 1922 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1948 at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Aug 1948 to 27 Aug 1948 and that I last saw him alive on 27 Aug 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arteriosclerotic Heart Dis. Bronchial asthma (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature William J. Hawn M. D.
Address South Baltimore Gen. Hosp. Date signed 8-27-48

VS 150

Correction is especially important. Physicians: please write the cause of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G66276 — CERTIFICATE OF DEATH — 131a — G66276

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Ruttland Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Beatrice Clary

(a) Residence: No. 909 Ruttland Ave. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

6a. If married, widowed, or divorced — HUSBAND of (or) WIFE of William Clary

6. DATE OF BIRTH (month, day, year) Aug. 27, 1882

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	-	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Norfolk, Va.

FATHER

13. NAME William Hill

14. BIRTHPLACE (city or town) (State or country) Norfolk, Va.

MOTHER

15. MAIDEN NAME Evelina Wright

16. BIRTHPLACE (city or town) (State or country) Norfolk, Va.

17. INFORMANT Preston Hill

(Address) 909 Ruttland Ave.

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Woodlawn, Va. Date Sept. 4, 1948

19. UNDERTAKER Geo. M. Nelson & Son

(Address) 1323 Eutaw Place

20. FILED ... 19 ...

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 8-29-1948

22. I HEREBY CERTIFY, That I attended deceased from July 15, 1948 to Aug 29, 1948

I last saw her alive on 8/29/48, 1948. Death is said to have occurred on the date stated above, at 2 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	1 year

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.

(Signed) Calvin B. LeCompte M. D.

(Address) 1113 N Caroline St

G66277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66277 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Walker
(c) Hospital or institution: St. Agnes 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 N. Charles St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie V. Eby

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife James H. Eby
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 27 1859

8. AGE: Years 89 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Samuel Shoe
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Carr
15. Birthplace Pa.

16 (a) Informant C. Arthur Eby
(b) Address 2530 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Henry McHenry Jenkins Jenkins & Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/28 1948 and that I last saw he alive on 8/28 1948.

Immediate cause of death Cerebral hemorrhage and anemia — Duration

Due to ? —

Due to — —

Other Conditions — —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Dwyer M. D.
Address St Agnes Hosp Date signed 8/29/48
Balto Md

VS 150

G66278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66278
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Street
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Davidsonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM OWENS TUCKER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	No	Male	White	Married

6 (b) Name of husband or wife Fannie N. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 4, 1880

8. AGE: Years	Months	Days	If less than one day
(67) 68	11	23	hr. min.

9. Birthplace Lathian, Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Benjamin L. Tucker
13. Birthplace Birdsville Maryland

MOTHER
14. Maiden Name Margaret Owens
15. Birthplace Lathian, Maryland

16 (a) Informant Mrs. Fannie N. Tucker
(b) Address Davidsonville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory All Hallows Cemetery
Location Annapolis, Maryland

18 (a) Funeral director John M. Taylor Annapolis, Md.
(b) Address 147-149 Gloucester Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 3.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Aug 27 1948 and that I last saw h alive on Aug 27 48.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Myocardial Degeneration	3 yrs
Due to Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Todd M.D.
Address 2108 E. Eutaw St. Date signed 8/29/48

correct age is especially important. Physicians, please write the cause of death plainly, and

YS 193

G66279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66279
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Anne Arundel
(c) City or town Jessup Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Champion Forest
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS JESSIE MALONE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1873.

8. AGE: Years 75 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace TAMAROS, ILL. (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name CYRIL WILLOUGHBY.
13. Birthplace ALA.

MOTHER
14. Maiden Name HARRIET PATRICK
15. Birthplace TENN.

16 (a) Informant MARION R. MALONE.
(b) Address CHAMPION FOREST, JESSUP, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Edenhill Cem.
Location SUITLAND MD.

18 (a) Funeral director J ARTHUR WALTERS.
(b) Address 505 WASH BLVD, LAUREL, MD.

19 (a) Date received AUG 29 1948 (b) Registrar for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-48 19 . at 12:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-48 19 to 8-29-48 19 , and that I last saw h[illegible] alive on 8-26-48 19 .

Immediate cause of death Resp. Failure

Due to Overwhelming Toxemia

Due to Rocky Mountain Spotted Fever

Other Conditions Bronchopneumonia Right Lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John White
Address Laur. Md. Date signed 8-29-48

VS 150

666280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

666280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Usns SS Alcoa Pennant
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Ashboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W. Worsham

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 41 | Months | Days | If less than one day: hr. min.

9. Birthplace Stokes N C (Town, county, and state)

10. Usual Occupation Steamen

11. Industry or business

FATHER: 12. Name John T Worsham
13. Birthplace N. C.

MOTHER: 14. Maiden Name Minnie Tillman
15. Birthplace N C

16 (a) Informant: W C Craven
(b) Address SS Alcoa Pennant

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 8/29/48 (month, day, year)

(c) Cemetery or crematory Ashboro
Location Ashboro N C

18 (a) Funeral director Hilliard Funeral Home
(b) Address 319 Front St Huntington West Virginia

19 (a) Aug 30 1948 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify type of work)
(d) Means of injury

23. Signature Emil L Rose M.D. Medical Examiner.
Date signed 29 Aug 48

G66281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Warren St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde Duncan

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1902

8. AGE: Years 45 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Cashmere Wa (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER 12. Name Peter McDuncan

13. Birthplace Kentucky

MOTHER 14. Maiden Name Agnes Grundy

15. Birthplace Kentucky

16 (a) Informant Mrs Margaret Duncan

(b) Address 411 Warren St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/41

(c) Cemetery or crematory Cashmere Wa

Location Cashmere Wa

18 (a) Funeral director Wilson & Dodd

(b) Address 219 E Pratt St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington for Wilson & Dodd Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1941, at 11:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Julianelle M.D. Medical Examiner

Date signed 8/29/41

666282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 666282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 21
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4238 Nicholas Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Doris Eckenrode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband ~~or wife~~ Geo. J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48	47		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas. Creighton

13. Birthplace Ind

MOTHER 14. Maiden Name Amelia Dietzel

15. Birthplace Ind

16 (a) Informant Hosp

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-48 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel

Location Rock Creek Park

18 (a) Funeral director Colgan & Lang

(b) Address Church & Huntington Aves

19 (a) AUG 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948, at 11:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1948, to 8-29-1948, and that I last saw her alive on 8-29-1948.

Immediate cause of death Cardiac Failure — **Duration**

Due to Hypostasis (HYPOSTATIC PNEUMONIA)

Due to possible Leukemia & Carcinoma of Peritoneum (SPLENIC)

Other Conditions Plaque (PRESSURE) with ~~metastases~~.

(Include pregnancy within 3 months of death)

Date of operation 8-15-1948

Major findings of operation: Carcinoma of peritoneal pleura

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature C. S. Thomas M. D.

Address Mercy Hosp. Date signed 8-24-48

VS 150

G666283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G666283 Registered No.

8-30a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Lakeland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Lakeland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Maud Hinks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John T. Hinks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 3 - 1878

8. AGE: Years 70 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name William B. T. Davis
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Jenny Painter
15. Birthplace Virginia.

16 (a) Informant George A. Davis
(b) Address 1345 W. Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (month) / 30 (day) / 48 (year)
(c) Cemetery or crematory Western Cemetery
Location Edmonson & Longwood Sts

18 (a) Funeral director John J. Bowman & Son
(b) Address 901-03 Hollins St

19 (a) AUG 30 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 28 1948 at 1 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15-1948 to 8-28-1948. and that I last saw h alive on 8-28-1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	2-3 years
Due to	
Other Conditions Bedsore	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeld M. D.
Address 2708 Hollins Ferry Rd Date signed 8/28/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓

G66284
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 82 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 East Fort Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Armstrong Robbins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Edward E. Robbins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11 - 15 - 65

8. AGE: Years	Months	Days	If less than one day
82	9	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Wm McCulley
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Eckhardt
15. Birthplace Germany

16 (a) Informant Mrs Edna Goss
(b) Address 809 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F Kleny Inc
(b) Address 716 Light St

19 AUG 30 1948 (Date Rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/1948 at 11:50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-27 1948 to 8-28 1948 and that I last saw her alive on 8-28 1948

Immediate cause of death: Diabetes mellitus with acidosis + coma — Duration ?

Due to: and Cardiovascular failure.

Due to: Arteriosclerosis, generalized Cerebrovascular accident, Femoral thrombosis

Other Conditions: Myocardial thrombus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Carlson M.D.

Address Maryland General Hospital Date signed 8/29

correct age is especially important. registrar. please write

X

666285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John Lloyd

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 28, 1872

8. AGE: Years 75 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name John Lloyd
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary K Piquett
15. Birthplace Baltimore

16 (a) Informant Edwin Thomas Lloyd
(b) Address 713 Gonsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

16 (a) Funeral director Jos F Flannery Inc
(b) Address 715 Light St

19 (a) AUG 30 1948 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 8/30/48

VS 131

66286 ✓ G66286

BALTIMORE CITY HEALTH DEPARTMENT Registered No. .....

CERTIFICATE OF DEATH 21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 E. Preston St.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-1
DIED AT HOME — KNOWN TO DR
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 44YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 E. Preston Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME Marie Crawford
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	MARRIED

6 (b) Name of husband or wife Robt. K. CRAWFORD
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) JUNE 25, 1904

8. AGE: Years	Months	Days	If less than one day
44	2	4	hr. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name WM. F. DUEBEL
FATHER 13. Birthplace MARYLAND
MOTHER 14. Maiden Name JULIA HENKLE
MOTHER 15. Birthplace MARYLAND

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 28 1948, to AUG. 29, 1948, and that I last saw her alive on Aug 28 1948.

Immediate cause of death	Duration
ADRENAL INSUFFICIENCY (Addison's Disease)	3 YRS
Due to TUBERCULOSIS of Adrenals	3YRS
Due to	
Other Conditions OLD INACTIVE APICAL PULMONARY TUBERCULOSIS (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Samuel P. Asper, Jr. M.D. M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Aug. 29, 1948

VS 150

66287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. 66287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Mohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret L. Mohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1879

8. AGE: Years 69 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business Federal Tin Co

FATHER
12. Name Daniel V. Mohler
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ann V. Morrison
15. Birthplace W. Va.

16 (a) Informant Margaret L. Mohler
(b) Address 300 E. Hamburg St.

17 (a) Removal (b) Date thereof 9/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hedgesville
Location Berkeley Co. W. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1247 St. Paul St.

19 (a) AUG 30 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/28/48 at 6.30 P.M.
(b) Where did injury occur? Charles & Barre Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Industry While at work? yes
(d) Means of injury Heat Stroke

23. Signature Earl L. Rogers M.D.
Medical Examiner

Date signed 29 Aug 48

VS 151

666288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) to-day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Purvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of ~~husband or~~ wife Edith Barrat Purvis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1873

8. AGE: Years 74 Months 10 Days If less than one day hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Silversmith

FATHER
12. Name Robert Cranmer Purvis
13. Birthplace Pa.

MOTHER
14. Maiden Name Cecilia Dodge
15. Birthplace Pa.

16 (a) Informant Mrs Elizabeth Muffs
(b) Address 2027 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month, day, year)

(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) AUG 30 1948 (Date Received) (b) Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948 at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Coronary Arteriosclerosis

Other Conditions Generalized A.S. Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 29 Aug 48

VS t81

66289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 66289

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton & Hilkens

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3432 Virginia ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ida Chamat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Late Ignatz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Ruben Zenty

13. Birthplace Russia

MOTHER

14. Maiden Name Laura (Dec'd)

15. Birthplace Russia

16 (a) Informant Mrs. M. Foley

(b) Address 3432 Virginia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Belair Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North Ave.

19 (a) AUG 30 1948 (Date received by registrar)

Funeral Director for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8/29 1948 and that I last saw her alive on 8/29 1948.

Immediate cause of death Respiratory Failure

Due to Carcinomatosis

Due to Carcinoma of the Stomach

Other Conditions Cachexia + Gastric bleeding

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of Stomach & metastasis

of autopsy:

Duration: Known duration 5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John J Tansey

Address St Agnes Hosp Date signed 8/29/48

Bull Med. X

6290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G66290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 746 Grantley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Martin Gerbig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife 33/44

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 1874

8. AGE: Years 74 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Gerbig
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace ?

16 (a) Informant John Gerbig
(b) Address 746 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location 3801 Frederick Ave.

18 (a) Funeral Director Frank Della Luca
(b) Address 322 S. High St.

19 (a) AUG 30 1948 (Date received by Registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1948, at 36. M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Aug 1948 to 27 Aug 1948, and that I last saw him alive on 26 Aug 1948.

Immediate cause of death: Acute Coronary Insufficiency — Duration
Due to: Hypertensive C.V. Disease
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Earl L. Rose M.D.
Address 172 Wellington Date signed 29 Aug 48

VS 150

666291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

666291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street 24
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Covington Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: GEORGETTA SHECKELS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel F. Sheckels
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 28, 1888

8. AGE: Years 60 | Months 4 | Days — | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Hunter
13. Birthplace Don't Know

MOTHER
14. Maiden Name Caroline Sheckels
15. Birthplace Balto Md

16 (a) Informant Samuel F. Sheckels
(b) Address 1528 Covington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director C. Howard Evans
(b) Address 1410 Eutaw St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1948, to Aug. 28 1948, and that I last saw him alive on Aug. 28 1948.

Immediate cause of death: Postoperative Bronchopneumonia — Duration: 3 days
Due to: Adenocarcinoma of Rectum
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 8-25-48
Major findings of operation: Adenocarcinoma of Rectum
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. D. Kennedy M. D.
Address 1213 Light St. Date signed 8-28-48

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

66292
SCa F90592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No. 666292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: Sp. St Balto. Bal. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Chaffman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1943

8. AGE: Years 4 | Months 8 | Days 19 | If less than one day: hr. min

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name David Kenny Chaffman Jr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jean —
15. Birthplace Balto Md

16 (a) Informant David Kenny Chaffman Jr
(b) Address 1732 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 '48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location

18 (a) Funeral director C. Howard Evans
(b) Address 1400 Shentaff Huntington Indiana, Md

19 (a) AUG 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948, at 4:28 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Peritonitis

Due to Ulcer Perforating Duodenum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 8/29/48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66293

G6293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1417 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 61 | Months: 3 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Isaiah Wesley
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Archbold
15. Birthplace: Md

16 (a) Informant: Andrew Palmer
(b) Address: 1417 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 1-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: James A. Stango
(b) Address: 1142 W. Pratt St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/28 1948 and that I last saw her alive on 8/28 1948

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Benign hypertension

Due to: Arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: Bruce Powell, Jr. M.D.
Address: Mercy Hosp. Date signed 8-29-48

X

VS 150

6294 2C-48-05402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 666294 Registered No. 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. Amity St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County Balto
(b) City or town (If outside city or town limits, write RURAL and give town)
(c) Street No. 121 N. Amity St (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy M. Pinder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-43

8. AGE: Years 5 | Months | Days 21 | If less than one day: hr min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Edward Pinder
13. Birthplace md

MOTHER 14. Maiden Name Elizabeth Mason
15. Birthplace md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A. Stango
(b) Address 1142 W. Fillmore St

19 AUG 30 1948 (Date received by registrar) Huntington Williams, M.D. (Physician or Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute gastro-enteritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 29 Aug 48

VS 151

666295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 666295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Do Balto. Gen. Hospital
(c) Hospital or institution: 1200 Blk. Light St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Jackson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA O. RUPP

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas F. Rupp
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 21 1891

8. AGE: Years 57 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ludwig Otto
13. Birthplace Germany

MOTHER
14. Maiden Name Julliana Neuman
15. Birthplace Germany

16 (a) Informant Thomas F. Rupp
(b) Address 1626 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Patapsco Highway

18 (a) Funeral director Richard Funeral Home
(b) Address 2-4 E. Chas. St.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Burlington, Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948 at 6:50 PM

21. I certify that death occurred on the date above stated that I attended deceased from — 19 .. to 8/29 1948
and that I last saw her alive on 8/29 1948

Immediate cause of death: Lobar pneumonia — Duration 2 days

Due to Dr

Due to

Other Conditions Diabetes mellitus — 6 mo.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Dunmire M.D.
Address 1213 Light St. Balto. 30. Date signed 8/29/48

108

correct age is especially important. Physicians: please write the clothes of death clearly and legibly.

VS 150

6296
AB-120206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 666296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 0s
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Elkins Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7- 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	8	21		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name David Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Zepp
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Winston E. Donovan
(b) Address 3630 Poland Ave Huntington Woods, Mich.

AUG 30 1948
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 19 48 at 12.15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 6-5- 19 48. to 8-28- 19 48. and that I last saw her alive on 8-28-48

Immediate cause of death Pulmonary metastasis

Due to Ovarian adeno-carcinoma

Due to

Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Nielsen M.D.
Address Balto City Hosp. Date signed 30 Aug 48

66297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 66297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3215 Dillon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHRINE [redacted] Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1864

8. AGE: Years	Months	Days	If less than one day
83	11	2	hr. min

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Pete Hummel

13. Birthplace Germany

MOTHER 14. Maiden Name not known

15. Birthplace Germany

16 (a) Informant George H. Clark

(b) Address 3215 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Clarence F. Hoffman

(b) Address 1639 Broadway

19 AUG 30 1948 (Date rec'd by registrar) Huntington Williams, Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 8:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-4 1946 to 8-26 1948

and that I last saw her alive on 19

Immediate cause of death

Cardiovascular C.V. Renal

Myocardial Failure

Due to Acute Coronary Occlusion.

Duration
1942
8-2-48
8-26-48

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify) (Yes or No)

(e) Means of injury

23. Signature E. A. Schimunek M. D.

Address 842 Eastern Ave Date signed 8-27-48

VS 150

066298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. 066298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Ramona Ave., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME METZGER, Boniface Joseph

3 (b) If veteran, name war --

3 (c) Social Security Account No. -- Unknown

4. Sex: m

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Doretta E. Metzger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1890

8. AGE: Years 57 | Months 11 | Days 0 | If less than one day: - hr. - min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Fireman (Seafarer) - American seaman

11. Industry or business Seafaring

FATHER
12. Name Joseph Metzger
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Ritter
15. Birthplace Germany

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North & Ross. Sts

18 (a) Funeral director Clayton F. Hitchcock
(b) Address 1639 Broadway

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 at 4:06 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1948 to Aug. 28 1948, and that I last saw him alive on Aug. 28 1948

Immediate cause of death: Congestive heart failure — Duration: 7

Due to Arteriosclerotic heart disease with auricular fibrillation. — Duration: 1

Other Conditions Arteriosclerotic nephritis with azotemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick
Address U.S. Marine Hospital, Date signed 8/28/48

VS 180

93D

6299
AB-80747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

G66299
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Frances (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 13- 1883-or 1884

8. AGE: Years	Months	Days	If less than one day
63 or 64		15	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER
12. Name John (D
13. Birthplace Poland

MOTHER
14. Maiden Name Ursala (D
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 31-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Walter, Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

AUG 20 1948 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 1948, at 1.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3- 1943, to 8-28- 1948, and that I last saw him alive on 8-28- 1948.

Immediate cause of death Bilateral far advanced pulmonary Tuberculosis & emphysema — Duration

Due to

Due to

Other Conditions Cerebral arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gayle B. Truold M. D.
Address BCH - FB Date signed 29 Aug 48

X

066300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 121a

Registered No. 066300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Sweeney
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Ward
15. Birthplace Ireland

16 (a) Informant Mrs. G. Noffsinger
(b) Address 418 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 AUG 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Aug 1948 to 28 Aug 1948 and that I last saw h[illegible] alive on 27 Aug 1948.

Immediate cause of death Uremia — Duration 3½ weeks

Due to Cardio-Vascular renal disease

Due to

Other Conditions Senile dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfield M. D.
Address 714 E. Preston St Date signed 30 Aug

X

correct age is especially important. Physicians: please write the cause of death plainly.

VS 189

AMMENHAUSER

666301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Catonsville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Ammenhauser

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4-1894

8. AGE: Years	Months	Days	If less than one day
54	7	23	hr. min.

9. Birthplace Balto Co Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Builders

FATHER
12. Name Oscar Ammenhauser
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Pfeiffer
15. Birthplace Md.

16 (a) Informant Mrs. Ceara Ricke
(b) Address 142 Collins ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City Md

18 (a) Funeral director Edw J May Nabb
(b) Address Catonsville Md

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1948, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Rupp M.D.
Medical Examiner
Date signed 28 Aug 48

66302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 502 S. Bradford St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella Link (Alexsandra Link)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leo David Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/95

8. AGE: Years 53 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Locust Point, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Karol Dewgillo
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ? Unknown
15. Birthplace Unknown

16 (a) Informant Leo. D. Link
(b) Address 502 S. Bradford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 AUG 30 1948 (Date rec'd by registrar) (Huntington for Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Aug 29 1948 and that I last saw h[illegible] alive on Aug 29 1948

Immediate cause of death Broncho-pneumonia — Duration

Due to Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Broncho-pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy C. Ruston Jr. M. D.

Address [illegible] Date signed Aug 29 1948

VS 150

G66303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G66303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Lexington St.
(c) Hospital or institution: Fayette Nursing Home
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 HAYWARD AVE. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME ELSIE M. WILSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) ~~Single, married~~, widowed, ~~or~~ divorced: widow

6 (b) Name of husband or ~~wife~~: Wm. —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 24, 1877

8. AGE: Years 71 | Months - | Days 4 | If less than one day: hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Christian Lehman
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Susana Hocke
15. Birthplace York, Pa

16 (a) Informant Mrs. Fannie C. Sadler
(b) Address 4119 Hayward Ave.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ David Ridge
Location Ridgeville

18 (a) Funeral director Wm. J. Turner & Sons
(b) Address Do Bth & Pa. Aves.

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 27 1948 and that I last saw her alive on Aug 27 1948.

Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension Cerebral Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry S. Hamilton M. D.
Address 1302 Lexington Date signed Aug 30

correct age is especially important. a typewriter

VS 150

66304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. George Edward Raines

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	--	male	wh	

6 (b) Name of husband or wife Bessie F. Raines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 30, 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
61	1	28		

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George E. Raines
13. Birthplace Va.

MOTHER
14. Maiden Name Ida F. Norwood
15. Birthplace Md.

16 (a) Informant Mrs. Bessie F. Raines
(b) Address 2731 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Pine Grove Cem.
Location Mt. Airy, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-48 19 . at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-28 1948 and that I last saw him alive on 8-28-48 19

Immediate cause of death Asphyxiation — Duration

Due to Cerebral hemorrhage following compression of head cavities.

Due to Hypertensive Cardio Vascular disease.

Other Conditions Bronchial pneumonia

Date of operation

Major findings of operation:

of autopsy:

(Include pregnancy within 3 months of death)

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert R. Reiny M.D.
Address Date signed 8-28-48

VS 150

G66305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G66305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry H. Hawkins, Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1931

8. AGE: Years 16 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Hawkins
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Herkrotte
15. Birthplace Balto.

16 (a) Informant Mr. A. V. Hawkins
(b) Address 759 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/40 (month) (day)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 30 1940 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1940, at P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Cervical Vertebrae (5th)

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 27 Aug at M.
(b) Where did injury occur? Loudon Park Cemetery
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Diving accident.

23. Signature [signature] M.D. Medical Examiner.
Date signed 28 Aug 40

VS 151

G66306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463

Registered No. G66306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. 24th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis L. Peer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife George W. Peer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1888

8. AGE: Years 59 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Vernon

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Muriel Perry

(b) Address 315 E. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Prince George's Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Signature of Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948 at 7:15 M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] Medical Examiner. M.D.

Date signed 8/29/48

6307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666307

13B

DB 121740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Ohio~~ (b) County
(c) City or town ? (If outside city limits give township) (and street and town)
(d) Street No. 1520 Piper Henryton Sanatorium (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Odell Grice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Alfonso
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1926

8. AGE: Years	Months	Days	If less than one day
22	7	2	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Milton Curry
13. Birthplace Ala.
14. Maiden Name Olbie Coleman
15. Birthplace Ala.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Youngstown Ohio
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St. Huntington West Va.

19 (a) AUG 30 1948 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1948 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1948 to 8-25- 1948, and that I last saw her alive on 8-25- 1948

Immediate cause of death shock. Duration 8 hour.

Due to Prolonged Levature 4 hou
Pneumothorax
Due to Pulmonary TB 3 yea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-25-48

Major findings of operation: TB.

of autopsy: same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J E Cook M. D.
Address 4940 Eastern Date signed 8-27-48

VS 15

66308 BC = C 322 K

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

184

Registered No. 66308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 W. Franklin St. (location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: GARY SCROGGINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1945

8. AGE: Years 2 | Months | Days | If less than one day: hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Calvin Scroggins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Evelyn Russell
15. Birthplace Balto. Md.

16 (a) Informant Evelyn Scroggins
(b) Address 727 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1948
(c) Cemetery or crematory Dan Hill A.M.E. Zion
Location Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 30 1948 (Date clerk issued permit) (b) Washington Williams, M.D. (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 8/25/48 Approx. 1:30pm.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work)
(d) Means of injury Firearms

23. Signature Carl L Royer M.D. (Medical Examiner)
Date signed 8/26/48

VS 191

66309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G66309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Riggs Avenue
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kelly Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Worsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1920

8. AGE: Years 28 | Months 5 | Days 5 | If less than one day: hr. min.

9. Birthplace Greenville, N.C. (Town, county, and state)

10. Usual Occupation Porter-University Hospital

11. Industry or business

FATHER
12. Name John Fleming
13. Birthplace Greenville, N.C.

MOTHER
14. Maiden Name Rena Knox
15. Birthplace Washington, D. C.

16 (a) Informant Ethel Fleming (wife)
(b) Address 1620 Riggs Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1948 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Balto. Md.

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder Str.

19 Aug 30 1948 (b) Katie R. Williams
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948, at 10:25 A. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub acute bacterial endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl R. Long M.D.
Medical Examiner.
Date signed 8-25-48

VS 15

G66310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G66310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Lafayette & John. 14
(c) Hospital or institution:
Woman's Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) Not Known.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Lehellenberg - (Marion Tennant Lehellenberg)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: WIDOWED

6 (b) Name of husband ~~or wife~~: Charles B. Lehellenberg

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) December 12, 1865

8. AGE: Years 84 | Months 8 | Days 17. | If less than one day: hr. min.

9. Birthplace Nova Scotia, Canada.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name John Carpen Tennant.
13. Birthplace England

MOTHER
14. Maiden Name Marion Martin.
15. Birthplace Canada

16 (a) Informant Mrs Frederick A. Kummer
(b) Address 230 W Lafayette Ave-Balto Md.

17 (a) Cremation (b) Date thereof 8-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart & Myers
(b) Address 108 W Monument

19 (a) (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948, to Aug 29 1948, and that I last saw her alive on Aug 29 1948.

Immediate cause of death
Bronchopneumonia — Duration 4 da

~~Due to~~ Cardio Vascular Accident — 1 week

Due to Arteriosclerotic Cardio Vascular Disease — not Known

Other Conditions Diabetes Mellitus — not Known

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Findings above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mark E Hall, M. D.
Address Women's Hospital Date signed 8/29/48

AUG 30 1948 Washington, D.C.

VS 180

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G66311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard St
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give township)
(d) Street No. 11 East Centre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hyman Fine

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)
8. AGE: Years 75 Months Days If less than one day hr. min
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Field Manager
11. Industry or business:

FATHER
12. Name: Abraham
13. Birthplace: Russia

MOTHER
14. Maiden Name: Minnie
15. Birthplace: Russia

16 (a) Informant: Clara Fine
(b) Address: 11 E Centre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory: Md Memorial Park
Location: Forman Mill Rd

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2120 Eutaw Place

19 AUG 30 1948 (Date rec'd by registrar) (b) Washington Wilkerson, Mitt Registrar

VS (15)

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948, at 2.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Aug 1948 to 29 Aug 1948 and that I last saw him alive on 29 Aug 1948.

Immediate cause of death: Acute Cardiac Failure. — Operation: 4 hours

Due to: Hypertension and Arteriosclerotic Cardio

Due to: Myocardial Disease, with Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil M. Sternberg M.D.

Address 10 W Mt Vernon Pl Date signed 29 Aug 48

666312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-1 Raynor Ave
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Classen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID SCHLEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jeanette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Fannie

15. Birthplace Russia

16 (a) Informant Dept Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Baker Sharp

Location Mt Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Pl.

19 AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Aug 30 1948; and that I last saw him alive on Aug 30, 1948.

Immediate cause of death, Acute pulmonary edema:

Due to Coronary thrombosis - myocardial infarction

Due to Hypertensive arteriosclerotic heart disease

Other Conditions Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad Teicher M.D.

Address West Baltimore Date signed Aug 30 '48

Gen Hosp.

VS 150

66313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87

Registered No. 666313

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mount Hope

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3104 Tioga Parkway (If rural give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME Mildred Kemler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 36 Months Days If less than one day hr min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lemon

13. Birthplace Russia

MOTHER 14. Maiden Name Sophie

15. Birthplace Russia

16 (a) Informant Nathan Kemler

(b) Address 3104 Tioga Parkway

17 (a) Burial, cremation, or removal Burial (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Har Israel

Location Southern Ave

18 (a) Funeral director Jack Levy Inc

(b) Address 2400 Eutaw Place

19 (a) AUG 31 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1948 at 5:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 27 1948 to Aug 30 1948, and that I last saw h[illegible] alive on Aug 30 1948

Immediate cause of death Septicemia

Due to Infected Bed Sores

Due to multiple Sclerosis

Other Conditions

(Include surgeries within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: days, months, years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. T. Krasnitsky M.D.

Address 3210 Eutaw Pl Date signed Aug 31 48

VS 150

66314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66314

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 E. East Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 E. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Robert Powell

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept 30 - 1872

8. AGE: Years 75 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Germany. (Town, County, and state)

10. Usual Occupation at Home

11. Industry or Business

FATHER 12. Name Otto Kreger

FATHER 13. Birthplace Germany.

MOTHER 14. Maiden Name Unk.

MOTHER 15. Birthplace

16 (a) Informant Charles Doach

16 (b) Address Taylor Ave. Essex

17 (a) Burial (Burial, cremation, or removal)

17 (b) Date thereof Aug. 31, 48 (month) (day) (year)

17 (c) Cemetery or crematory Mt. Carmel

Location O'Donnell St.

18 (a) Funeral director John J. Connelly.

18 (b) Address 46 Eastern Ave.

19 (a) AUG 30 1948 (Date rec'd by registrar)

19 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 25 1948 to Aug 27 1948 and I that I last saw him alive on Aug 26 1948

Immediate cause of death Coronary Thrombosis — Duration 1 Week

Due to

Due to

Other Conditions

(Indicate pregnancy, childbirth, or abortion if any of these conditions contributed to cause of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

24. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny, D.

Address 400 E Madison Date signed 8/30/48

VS 150

666515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. 666515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3912 Pulaski Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 391x Pulaski Highway
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse L. Anders

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1991

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 18 1891

8. AGE: Years 57 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace: Baltimore MD
(Town, county, and state)

10. Usual Occupation: Truck Loader

11. Industry or business

FATHER
12. Name: Jesse L Anders
13. Birthplace: Md

MOTHER
14. Maiden Name: Minnie M Cramer
15. Birthplace: Md

16 (a) Informant: Mrs M M Anders
(b) Address: 3912 Pulaski Highway

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 8/30/48
(c) Cemetery or crematory: Loraine
Location: Baltimore Md

18 (a) Funeral director: Hilton Cook Co
(b) Address: 2400 Pont St

19 (Date received by registrar) AUG 30 1948 Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/26/48 19 at 11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature: John R Davis M.D.
Medical Examiner
Date signed: 8/27/48

VS 151

WITH CHIEF MEDICAL EXAMINER
FOR APPROVAL.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666316

G6316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyoming Ave. near Edgewood
(c) Hospital or institution: Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County PRINCE GEORGE
(c) City or town CLINTON, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME ROBERT ALLEN CRONE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-1947

8. AGE: Years 1 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace LA PLATA, PRINCE GEORGE, MD.
(Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business —

12. Name EVERETT ALLEN BOSWELL

13. Birthplace BRANDYWINE, MD.

14. Maiden Name FRANCIS ATKINS CRONE

15. Birthplace DANVILLE, VA.

16 (a) Informant EVERETT A. BOSWELL

(b) Address CLINTON, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Columbia Mausoleum

Location Washington, D.C.

18 (a) Funeral director Ulmer Funeral Home

(b) Address 2018 Baltimore Blvd. Hyattsville for Williams

19 (a) AUG 30 1948 (Date received by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1948 to 8-28 1948, and that I last saw him alive on 8-28 1948.

	Duration
Immediate cause of death SHOCK	
DUE TO ACUTE INTESTINAL OBSTRUCTION	2 HOURS
Due to MEGA COLON	10 MOS.
POST-ENCEPHALITIC SPASTIC PARAPLEGIA	10 MOS
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: TORTION OF MEGACOLON

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature O. Donald Ottenman M. D.

Address Childrens Hospital School Date signed 8-29-48

In absence of Dr. Ottenman by Howard J. Masters, M.D.

VS 3

G66317 | 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. G66317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES ADDISON

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-41

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Addison
13. Birthplace Md

MOTHER
14. Maiden Name Margaret
15. Birthplace Md

16 (a) Informant Anna R. Marshall
(b) Address 3118 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month)
(c) Cemetery or crematory Mt Calvary
Location Q. R. Co

18 (a) Funeral director Payne Sanders
(b) Address 1412 E. Preston St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 9.35a.m.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer, M.D. per: Howard J. Madden M.D. Medical Examiner.
Date signed August 27, 1948

VS 151

G663318 CUNNINGS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

Registered No. G663318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 Weaver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Weaver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos Cunnings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 9-1902

8. AGE: Years 46 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Green Cunnings

13. Birthplace Ga.

MOTHER 14. Maiden Name Nancy Cunnings

15. Birthplace Ga.

16 (a) Informant Annie Cunnings

(b) Address 427 Weaver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co.

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

1948 AUG 30 1948 (b) Registrar

(Date received by Registrar)

Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 27 1948 and that I last saw h alive on 19

Immediate cause of death Pulmonary Tuberculosis — Duration 4 Yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Johnson M.D.

Address 2329 Guilford Ave Date signed Aug 31 1948

correct age is especially important. physician: please write plainly

5319 C-673073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 WISTERIA AVE
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1YR 5MOS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 WISTERIA AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH MARIE COUNTESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1947

8. AGE: Years	Months	Days	If less than one day: hr.	min.
1	5	28		

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER 12. Name Edward W Countess

13. Birthplace Balto

MOTHER 14. Maiden Name Elizabeth [illegible]

15. Birthplace Balto

16 (a) Informant Edward Countess

(b) Address 3208 Wisteria Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Edmondson Avenue

18 (a) Funeral director Lilly & Zeily Inc.

(b) Address 403 S Gilmore St

19 (a) AUG 30 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug' 1948, at 1215 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw h alive on 19

Immediate cause of death: Asphyxia due to aspiration of Vomitus

Due to Vomiting

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

Duration: 30 minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide [redacted]
(b) Date of occurrence [redacted] at [redacted] M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature John A Toms M.D.

Address Date signed

VS 150

X

666320 C-C50166 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 666320

CERTIFICATE OF DEATH 24a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lemmon & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Coppleton St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty L. Burr

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4 Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1946

8. AGE: Years 2 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William H Burr
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Bona L Godley
15. Birthplace N Carolina

16 (a) Informant Mrs William H Burr
(b) Address 406 S. Coppleton St.

17 (a) burial (burial, cremation, or removal) (b) Date thereof 8/31/48 (month, day, year)
(c) Cemetery or crematory Cedar Hill Cem
Location Old Frederick Highway

18 (a) Funeral director John J Bowman Son
(b) Address 9603 Pulaski Hwy

19 (a) AUG 30 1948 (b) Registrar Washington Williams

Registrar of Vital Statistics

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948 to Aug 28 1948, and that I last saw h[illegible] alive on Aug 28 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Septicemia ??	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.
Address 609 N. Monroe St Date signed 8/31/48 M. D.

Shorofsky

Ebeler

666321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

666321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026 N. Rogers Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4026 N Rogers Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine L. Ebeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Adolph A. Ebeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 1876

8. AGE: Years 72 | Months | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Johnigen

13. Birthplace Germany

MOTHER 14. Maiden Name Hykeman

15. Birthplace Germany

16 (a) Informant Harry H Ebeler

(b) Address 4026 N. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1948 (month) (day) (year)

(c) Cemetery or crematory St Pauls

Location Druid Hill Park

18 (a) Funeral director Harry H Cruickshank

(b) Address 4714 Reisterstown Ave

19 (a) Aug 30 1948 (Date received) Carrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948 at 10 45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of the Bladder (urinary)

Due to

Other Conditions Cystitis Chronic Generalized
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert B. Waddell M.D.
Medical Examiner.

Date signed 8-29-48

VS 191

666322 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ 666322

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 E. Fairmount Ave.
(c) Hospital or institution:

6-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa K. Zapf

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herman Zapf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1869

8. AGE: Years	Months	Days	If less than one day
79	3	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Daniel Pfennig
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Miller
15. Birthplace Germany

16 (a) Informant Miss Marie Zapf
(b) Address 2505 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 31/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto. Md.
18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.
19 (a) AUG 30 1948 (Date received by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28th 1948, at 10:30 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23rd 1948, to Aug 28th 1948 and that I last saw h[er] alive on Aug 28th 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days
Due to arteriosclerosis
Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur abo[ut] home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury
23. Signature H. Jos. Faulkner M. D.
Address 1000 N. Miller Date signed 8/29/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 189

+

Dr. Harbold
66323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C66323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SUSAN ANN AMOS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. Thomas Amos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 29, 1859

8. AGE: Years	Months	Days	If less than one day
89	0	0	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Carroll S. Amos
(b) Address 3316 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Balto Co Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) AUG 30 1948 (Date rec'd by Registrar) Registrar Address 5306 Harford Road

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948 at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 29 1948 and that I last saw h alive on Aug 28 1948

Immediate cause of death Chronic Myocarditis — Duration ?

Due to Heart prostration Arteriosclerosis

Due to

Other Conditions uraemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold, M.D.
Address 5306 Harford Road Date signed 8/30/48

VS 150

G66324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66324 Registered No. G 66324

1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS J.B. STURM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Mary Sturm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Sturm
13. Birthplace

MOTHER
14. Maiden Name Katherine Kaltenbach
15 Birthplace

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, '48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director L.J. Ruck
(b) Address 5305 Harford Road

19 (a) 8/30/48 (Date rec'd by registrar) (b) Tentative Certificate

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 5:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948 to Aug 28 1948, and that I last saw him alive on Aug. 28 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 15 hrs.

Due to: Hypertensive Cardio-vascular Disease — 21 mos.

Due to: over

Other Conditions: Generalized Arterio-sclerosis; Peptic Ulcer.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Li Rosa M. D.
Address Mercy Hosp. Date signed 9-17-48

Chairman of Surg. Staff

Dr. Brennan

66525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 66525

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3109 Gibbons Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3109 Gibbons Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothea Kinlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry Kinlein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 7, 1859

8. AGE: Years	Months	Days	If less than one day
89	1	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name George Stengel

13. Birthplace ?

MOTHER 14. Maiden Name Margaret Glotzbach

15 Birthplace Germany

16 (a) Informant Mrs. Thomas Maskell

(b) Address 3109 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director Leonard J. Rauck

(b) Address 5305 Harford Road #14

19 (a) AUG 30 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Aug 1948, and that I last saw her alive on July 1948.

Immediate cause of death Carcinomatosis

Duration

Due to Primary Carcinoma of left breast.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas J. Brennan M.D.

Address 5217 Harford Rd Date signed 8-29-48

VS 150

Dr. Harbold
666326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. 666326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Basehart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1886

8. AGE: Years	Months	Days	If less than one day
62	0	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Basehart
13. Birthplace Balto.

MOTHER
14. Maiden Name Mattie Frostburg
15. Birthplace Holland

16 (a) Informant Mr. Harvey J. Basehart
(b) Address 4614 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Filed (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948 to Aug 26 1948 and that I last saw h[illegible] alive on Aug 26 1948.

Immediate cause of death Chr Myocarditis — Duration 10 yrs

Due to Arteriosclerosis (generalized)

Due to Alcoholism

Other Conditions Cirrhosis Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.
Address 4206 Harford Road Date signed 8/27/48

Huntington Antoine, M.D.

92D

VS 150

C66327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. C66327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Evergreen Ave
(c) Hospital or institution D.O.A. 2802
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city limits, write RURAL and give town)
(d) Street No. 2802 Evergreen Ave
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Hervey B. Foutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ella M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9-1865

8. AGE: Years	Months	Days	If less than one day
82	8	20	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ~~Solomon~~ Foutz
13. Birthplace Md

MOTHER
14. Maiden Name Miriam Cook
15. Birthplace Md

16 (a) Informant Mrs. Ella M. Foutz
(b) Address 2802 Evergreen

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto

18 (a) Funeral director L. J. Funk
(b) Address 5305 Harford Rd

19 (a) AUG 30 1948 Hunting of Notaries, Md
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 19 48 at 5 1/4 M

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schmidt M.D.
Medical Examiner.
Date signed 8/29/48

66328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Scene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7d.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 8421 Old Harford Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Frank M Oppisich

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	(Married)

6 (b) Name of husband or wife: Margaret S.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1-1890

8. AGE: Years: 57 | Months: 11 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Balto - Maryland (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Horse Collar Seal

FATHER
12. Name: Louis Oppisich
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Margaret Hulsey
15. Birthplace: Maryland -

16 (a) Informant: Patient.
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/31/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: Leonard J. Luck
(b) Address: 5305 Harford Rd.

19 (a) AUG 30 1948 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-28 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948, to 8-28 1948 and that I last saw h-m alive on 8-28 1948

Immediate cause of death: Respiration suffocation — Duration: min

Due to: Acute gastric dilatation — Duration: hrs

Due to: Carcinoma rectum — Duration: —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 8-26-48

Major findings of operation: Carcinoma rectum Resection

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. P. Sloan, M. D.

Address: Chas Hosp. Date signed: 8-30-48

V3 190

66529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Idaho Ave. D.O.A.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Idaho Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Coggins

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) November 7, 1863

8. AGE: Years 85 | Months 8 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Baltimore Transit Co.

11. Industry or business Retired

FATHER
12. Name Robert Coggins
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Cox
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Coggins
(b) Address 4102 Idaho Avenue -6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 30 1948 (Date rec'd by Registrar) Huntington Mahoney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 19 48 at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Lubowski M.D.
Medical Examiner.
Date signed 8/29/48

VS 151

666530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

✓ 666530 Registered No.

BC. 48-18892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 McElderry Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 McElderry Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred J. Carmon FREDDIE JAMES CARMON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-48

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Freddie James Carmon
13. Birthplace North Carolina

MOTHER
14. Maiden Name Geraldine Grady
15. Birthplace North Carolina

16 (a) Informant: Artemus Grady
(b) Address 1210 McElderry Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Wm. R. T. Elliott & Daughter
(b) Address 1121 N. Carrollton Ave.

19 (a) Aug 30 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Aug 1948; at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 24 Aug 48

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G66331

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66331
Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Laurens A
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) No 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Laurens A.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Anna Austin

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-6361

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife James Allen Austin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	13	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Clark
15. Birthplace Md.

16 (a) Informant William Blunt
(b) Address 516 Laurens W

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location, Halethorpe Md.

18 (c) Funeral director George T. O. Gibson Sr.
(b) Address 1735 Druid Hill Ave

19 (a) (Date received by registrar) (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 19 48 at 10 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 19 48 to Aug 27 19 48 and that I last saw her alive on Aug 27 19 48

Immediate cause of death Cardio Vascular Renal Disease — Duration 8 mo's
Due to Anemia — 3 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. William Tracy
Address 1928 Penna Ave Date signed 8/31/48 M. D.

VS 150

correct are is especially important. Physicians: please write and spell plainly.

G66332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66332 51B Registered No. 3690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Stockton St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Stockton St. (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gonzin Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie Gray | 6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years: 58 | Months | Days | If less than one day: hr. min.

9. Birthplace: Bowie Md. (Town, county, and state)

10. Usual Occupation: Plaster + Powder mixer

11. Industry or business

FATHER
12. Name: George Gray
13. Birthplace: Bowie Md.

MOTHER
14. Maiden Name: Mary H. Ryles
15. Birthplace: Bowie Md.

16 (a) Informant: Mrs. Mamie Gray
(b) Address: 1119 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Md.

18 (a) Funeral director: Geo. B. Kelly
(b) Address: 1303 Presstman

AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1948, to 8-28 1948, and that I last saw him alive on 8-27 1948.

Immediate cause of death: Carcinoma of prostate

Duration: About 2 years

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Franklin Saunders, M. D.
Address: 29 N. Stricker St. Date signed 8-28-48

VS 150

X

G66633

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66633 Registered No.

CERTIFICATE OF DEATH 135B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William John Olivey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife Mrs Carrie Olivey
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr) ? 74

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business Religious

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant: Wm T Long (step son)
(b) Address 1619 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location, Md

18 (a) Funeral director Ley. S. Kelson
(b) Address 1303 Pressman St.

AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1948, at 10⁰⁵ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-1948 to 8-27-1948, and that I last saw h~~im~~ alive on 8-27-1948

Immediate cause of death Cardiac failure — Duration

Due to Pyrexia, uremia

Due to T[illegible] infection

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature A M Purcell M.D.
Address Mercy Hospital Date signed 8-28-48

G66334 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66334 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street 25
(c) Hospital or institution: South Baltimore General Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 4
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cor. Hanover St. & Bristol Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON SCHILLING

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	8	15		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business Owns
FATHER 12. Name Wm. H. Schilling
13. Birthplace Md.
MOTHER 14. Maiden Name Mary E. Cook
15. Birthplace Md.
16 (a) Informant Family
(b) Address 3914 Hanover St.
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Parkville
18 (a) Funeral director J. W. Cauley
(b) Address 1302 E. Fort Ave.
19 (a) (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948, to Aug 27 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death	Duration
Generalized Peritonitis	
Due to Perforation of Colon	
Due to Carcinoma Splenic Flexure of Colon	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-6-48, & 8-12-48

Major findings of operation: Carcinoma of Splenic Flexure of Colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1213 Light St. Date signed 8-27-48.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66335 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 E Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2738 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Ella Wilson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1859

8. AGE: Years 89 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Oyster Retir ed

11. Industry or business

FATHER 12. Name: Dont Know
13. Birthplace

MOTHER 14. Maiden Name: Dont Know
15. Birthplace

16 (a) Informant: Mrs Elizabeth Somers
(b) Address: 2738 E Baltimore St

17 (a) (Burial, cremation, or removal): Burial (b) Date thereof (Aug 31 1948)
(c) Cemetery or crematory: Parkwood
Location: Balto Co Md

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans

19 (a) 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948 at 9 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Aug 28 1948, and that I last saw him alive on Aug 28 1948

Immediate cause of death: Uremia — Duration: 8/28/48
Due to Chr. Myocarditis — 1/1/47
Due to Senile Arterio Sclerosis — 1/1938
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: William J Uhrich M. D.
Address: 501 n Eutaw St Date signed: 8/29/48

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G66336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G66336

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N Castle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Scarborough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Scarborough
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) Nov 8 1888

8. AGE:

Years	Months	Days	If less than one day
59	9	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Yardman
11. Industry or business Establishment

FATHER
12. Name Wm Scarborough
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Repp
15. Birthplace Md

16 (a) Informant Elizabeth Scarborough
(b) Address 519 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Edmondson Ave

(a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28th 19 , at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to Aug 27 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death

Carcinoma of Pancreas — Duration: 10 mos

Due to

Due to

Other Conditions Pulmonary Embolism
(Include pregnancy within 3 months of death)

Date of operation Aug 29/48

Major findings of operation: Carcinoma of Head of Pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Frank J. Ayd, M. D.
Address 2005 Edmondson St Date signed 8/29/48

G66337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66337 Registered No. 309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Milliman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1910

8. AGE: Years: 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Jo Davis
13. Birthplace Ala.

MOTHER 14. Maiden Name Fannie Mae Davis
15. Birthplace Ala.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore Md

18 (a) Funeral director Edward O. Wilson
(b) Address 1017 Bentley ave

19 (a) Aug 30 1948 (Date received by registrar) (b) Interring for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-26 1948, and that I last saw him alive on 8-26 1948.

Immediate cause of death: Cerebrovascular accident — Duration: 20 min
Due to: arteriosclerosis and/or Syphilis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/26/48

VS 150

G66338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

✓ G66338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provt. Baltimore General 12 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 + hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Bishop Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Atkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 51 (Mos) Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER 12. Name Sandy Atkins

13. Birthplace Va

MOTHER 14. Maiden Name Calatha Atkins

15. Birthplace Va

16 (a) Informant Mrs Florine Atkins

(b) Address 216 N Bishop ave

17 (a) Burial, cremation, or removal Burial (b) Date (month, day, year)

(c) Cemetery or crematory Blackstone Mem Park

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1020 E Brantley Ave

19 (a) Date rec'd by registrar (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 28 - 1948, at ✓ 20 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Pelvis
Ruptured urinary bladder
Due to Ruptured gut.
Other Conditions Acute Peritonitis
(Include pregnancy within 3 months of death.)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-27-48 at 11.05 A.M.
(b) Where did injury occur? Fenwick: Belgian Rd, nr Thomas Run
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Struck auto. turned over.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8-28-48

X

G666339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G666339
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E Lanvale St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jane Doe

3 (b) If veteran, name war ..... | 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife John Doe
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unk.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	9			

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Beaby
13. Birthplace Md

MOTHER
14. Maiden Name Kate
15. Birthplace A. A. Co. Md

16 (a) Informant Rita Smith
(b) Address 414 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 49 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A Co Md

18 (a) Funeral director Paul E Gladhill
(b) Address 1515 McCulloh St

19 (a) (Signature of registrar) (b) Date received ..... (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1949 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 27 1949.
and that I last saw h[illegible] alive on Aug 27 1949.

Immediate cause of death Hypostatic Pneumonia — Duration 24 hrs
Due to Coronary Thrombosis
Due to Essential Hypertension
Other Conditions Arteriosclerosis Generalized Severe
Chronic Hypertrophic Arthritis
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Emerson L Julian
Address 1207 Madison Ave Date signed 8/27/49

93E

Please write the causes of death clearly and legibly. Physicians: Please write the causes of death clearly and legibly. The correct age is especially important.

G66340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Cloverdale Rd
(c) Hospital or institution: D-1A

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town) 3
(d) Street No. 1221 Cloverdale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1880

4. Sex M | Color or race W | 5 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice B. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1896

8. AGE: Years 52 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John H. Brown
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rebecca Hill
15. Birthplace W. Va.

16 (a) Informant Mrs. Beatrice B. Brown
(b) Address 1221 Cloverdale Road

17 (a) Burial (b) Date thereof 8-31-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Baltimore St., Md.

AUG 30 1948
(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration
Hypertrophy + dilatation
of the Heart
Mitral insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/27/48

VS 131

66341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

G66341

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 Aisquith Street

(c) Hospital or Institution:

Convent of Notre Dame 10 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Aisquith Street (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country County Cavan, Ireland

3 (a) FULL NAME Sister Laura Monaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1878

8. AGE: Years	Months	Days	If less than one day
70	2	11	hr. min.

9. Birthplace County Cavan, Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER

12. Name Philip Monaghan

13. Birthplace County Cavan, Ireland

MOTHER

14. Maiden Name Rose Fitzpatrick

15. Birthplace County Cavan, Ireland

16 (a) Informant Sr. M. Stan. Kostka

(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. Md.

18 (a) Funeral director

(b) Address

19 (a) AUG 30 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1936, to Aug. 29 1948, and that I last saw her alive on Aug 28 1948.

Immediate cause of death Uremia

Due to Hypertension

Due to Arteriosclerosis Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Francis J. Kurly M. D.

Address 110 E. Fort Ave Date signed 8/30/48

VS 150

correct age is especially important. Physicians, please write plainly

G66342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66342

G66342

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2326 E. Preston St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2326 E. Preston St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William W. Morrison

3 (b) If veteran, name war: Spanish War & World War I

3 (c) Social Security Account No. 201-18-9903

4 Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Morrison

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) 7-13-1881

8. AGE: Years 67 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Rochester N. Y. (Town, county, and state)

10. Usual Occupation U. S. Army

11. Industry or business Retired

FATHER

12. Name Joseph Morrison

13. Birthplace Rochester N. Y.

MOTHER

14. Maiden Name Harriet Hatfield

15 Birthplace Rochester N. Y.

16 (a) Informant Margaret E. Morrison

(b) Address 2326 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Belair Road & Philadelphia Rd.

18 (a) Funeral director Wm. J. Miller Sons

(b) Address 2121 E. Oliver St.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Hollidaysburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2-1948 to 8-28-1948 and that I last saw him alive on Aug 26 1948

Immediate cause of death Myocarditis — Duration 3 wks

Due to Arteriosclerosis — 5 yrs

Due to Emphysema — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Erik H. Printzmetal M. D.

Address 9858 Dayford Rd Date signed 8-29-48

VS 159

G66343

BC- 4P-18588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G66343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 25-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Nuth Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Boby Boy Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-48

8. AGE: Years | Months | Days | If less than one day 12 hr. 7 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Edward W. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Prasch
15. Birthplace Baltimore, Md.

16 (a) Informant Loretta Jones
(b) Address 5304 Nuth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto Md

18 (a) Funeral director Leonard J. Rock
(b) Address 530 S Paca St

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 27 1948 and that I last saw him alive on Aug 27 1948.

Immediate cause of death Circulatory Collapse — Duration 1 hr
Due to Concussion — Duration hrs
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury

23. Signature Thomas L. Bennett M.D.
Address Mercy Hosp. Date signed 8/30/48

VS 150

666344

666344

SC-B 86944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave

(c) Hospital or institution St Agnes Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town SUNSET BEACH PASADENA R.D. Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Herbert L Brown Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 22, 1947

8. AGE: Years	Months	Days	If less than one day
1yr	0	7	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER

12. Name Herbert J Sr.

13. Birthplace Williamsport Pa

MOTHER

14. Maiden Name Anna T Mitchell

15. Birthplace Wash D.C.

16 (a) Informant Mrs Herbert L. Brown, Sr. Sr.

(b) Address Sun Set Beach, Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn Md R.F.D.

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md.

AUG 30 1948 (Date Rec'd by Registrar) Washington Nottingham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/48 19 58 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/29 1948 to 8/29 1948 and that I last saw him alive on 8/29 1948.

Immediate cause of death	Duration
(a) Acute Lymphatic Leukemia & Terminal	
Due to (b) Massive Subdural & Subarachnoid	
Due to (c) Unknown Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Strange M.D.

Address St Agnes Hosp Date signed Balto md 8-29-48

VS 150

G66345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

2006

G66345
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 N. Montford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS FOGEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE: 62 Years | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Continental Can Co.

FATHER
12. Name John Fogel
13. Birthplace Hungary

MOTHER
14. Maiden Name Rosa Barbernitz
15. Birthplace Hungary

16 (a) Informant George M. Robinson
(b) Address 1103 Darley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-48 (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley Memorial Gardens
Location Belair Rd.

18 (a) Funeral director John H. Muller
(b) Address 2334 Jefferson St.

19 AUG 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948, at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
unable to make diagnosis

Due to Putrefactive changes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Tuttle M.D.
Medical Examiner.
Date signed 8/30/48

VS 151

G66646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

G66646
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Gibbons Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME V. LESLIE ZENTZ

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Lillian T. Zentz
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	7	hr. min.

9. Birthplace: Adams Co., Pa. (Town, county, and state)
10. Usual Occupation: Mgr.
11. Industry or business: Hardware Co.

FATHER
12. Name: Aaron Davis Zentz
13. Birthplace: Adams Co., Pa.

MOTHER
14. Maiden Name: Margaret A. Kiser
15 Birthplace: Carroll Co., Md.

16 (a) Informant: Mrs. Lillian T. Zentz
(b) Address: 2604 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 30 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1948 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 8/29 1948 and that I last saw h alive on 8/29 1948.

Immediate cause of death: Respiratory Circulatory failure

Due to: Hypostatic Pneumonia

Due to: Cerebral hemorrhage

Other Conditions: Generalized Arteriosclerosis

SES

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(e) Means of injury —

23. Signature: James Metz
Address: 5106 Harford Rd. Date signed: M 8/30/48 D

X

G66347 BALTIMORE CITY HEALTH DEPARTMENT ✓ G66347
CERTIFICATE OF DEATH 122B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette, Johns STREETS
(c) Hospital or institution:
HOSPITAL FOR WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 DA.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 DA.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. VA. (b) County —
(c) City or town CHARLESTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 GRANT ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA EDITH GIBSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife DAVID ROY GIBSON
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JAN 10, 1891

8. AGE: Years 57 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace LEWISBURG, WEST VA. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Andrew JOHN HUTCHISON
13. Birthplace Greenbrier Co W. VA.

MOTHER
14. Maiden Name Catherine MARY HUTCHISON
15. Birthplace Somerset Co MD.

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory
Location Charleston, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) AUG 30 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 AUGUST 1948 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 JULY 1948 to 30 AUG. 1948 and that I last saw her alive on 30 AUG. 1948.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration 8-12 HRS.

Due to TOXEMIA, EMACIATION — 22 DA.

Due to POST OPERATIVE WOUND INFECTION — 30 DA.

Other Conditions FECAL FISTULA; HYDROTHORAX, LEFT - CAUSE ? (Include pregnancy within 8 months of death)

Date of operation JULY 29, 1948

Major findings of operation: INTESTINAL ADHESIONS - GASTRITIS

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. McCord Jr.
Address Johns Hopkins Hospital Date signed 8/30/48

VS 150

correct age is especially important. Physicians: please write and spell names plainly.

G66348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G66348
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maternity

4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, give RURAL and give township)
(c) Street No. 517 West Mulberry Street
(If rural route, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. GUYER

GUYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18 1872

8. AGE: 75 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Harrisonburg Va
(Town, county, and state)

10. Usual Occupation Cigar Maker

11. Industry or business

FATHER
12. Name Peter Guyer
13. Birthplace Oak Bridge Va

MOTHER
14. Maiden Name Martha Kelly
15. Birthplace Harrisonburg Va.

16 (a) Informant William Belinsky
(b) Address Harrisonburg Va.

17 (a) Burial (b) Date thereof Sept. 1st/48
(Burial, cremation, or removal) (month)

(c) Cemetery Woodbine
Location Harrisonburg Va

18 (a) Funeral director Frank Dolly Hoover
(b) Address 322 S. High St.

19 (a) AUG 30 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/48 19 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Deaver M.D.
Medical Examiner.
Date signed 8/26/48

VS 151

G66349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9:D

G66649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Ramsay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Ramsay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Leon Edwards

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George B. Edwards
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1867

8. AGE:

Years	Months	Days	If less than one day
81	5	7	hr. min.

9. Birthplace Prince George's County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Austin L. Adams.
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Hatton
15. Birthplace Maryland

16 (a) Informant George B. Edwards
(b) Address 2223 Ramsay Street

17 (a) Burial (b) Date thereof 8-31-48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

AUG 30 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1948 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Aug 28 1948, and that I last saw h-- alive on Aug 27 1948.

Immediate cause of death
Pulmonary Edema.
Due to Cardiovascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Ketch M.D.
Address 251 W. Lanvale Date signed Aug 29/48

VS 150

G66350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G66350

472199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 W. Fayette, St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LEMON Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	married

6 (b) Name of husband or wife Rebecca Shaw
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) 10-2-95

8. AGE: Years	Months	Days	If less than one day
52	10	26	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Dave Shaw
13. Birthplace N. C.

MOTHER
14. Maiden Name Roxie Hanner
15. Birthplace N. C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Rock of Ages Branch
Location Wilson - N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 511 Belvidere ave Huntington Williamsport

AUG 30 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 28 1948 at 5. A M -25-

21. I certify that death occurred on the date above stated, that I attended deceased from 8-24- 1948 to 8-28- 1948 and that I last saw him alive on 8-28- 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to Hypertensive arterio - Sclerotic Vascular disease — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Ross
JOHNS HOPKINS HOSPITAL
Address Date signed 8/28/48

VS 159

5351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 164a

✓ G66351

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Long Island, Babylon
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 Oak Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Royal J. Field

3 (b) If veteran, name war

3 (c) Social Security Account No. 091-16-6438

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mabel G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1908

8. AGE: Years 40 | Months 2 | Days 20 | If less than one day hr min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER 12. Name Henry Field
13. Birthplace U.S.

MOTHER 14. Maiden Name Elizabeth Monroe
15. Birthplace U.S.

16 (a) Informant
(b) Address

17 (a) Cremation (Burial, cremation or removal) (b) Date thereof 9-3-48 (month, day, year)
(c) Name and location of cemetery or crematory

18 (a) Funeral director
(b) Address

(Date rec'd by registrar) AUG 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 48 at 10:43 M

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-30-48 at Approx. 8 A. M.
(b) Where did injury occur? B&O Wharf---Locust Point, Pier #3
(c) Did injury occur at home, on farm, industrial place, in public place? Wharf While at work? Yes
(d) Means of injury Hanged self by electric wire from drain pipe

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 8/30/48

VS 131

6352

JL - 122348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 666352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2710
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Craig Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6. 1878

8. AGE: Years	Months	Days	If less than one day
69	11	22	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Kerns
13. Birthplace Pa.

MOTHER 14. Maiden Name Ruth McDowell
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 31 1948 (Date received by local registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 9.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1948 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948

Immediate cause of death Pulmonary edema — Duration 2 days

Due to Hypertensive Cardio-vascular Disease — 5 yrs

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Keating M.D.
Address Balto City Hosp Date signed Aug 29 48

VS 150

X

6353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66353
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John F. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30th 1867

8. AGE: Years	Months	Days	If less than one day
81	3	29	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Darington Thomas
13. Birthplace Md.

MOTHER 14. Maiden Name Annie E. Creighton
15 Birthplace Md.

16 (a) Informant John F. Morris
(b) Address 2536 W. Fairmount Ave

17 (a) Burial (b) Date thereof 8/31/48
(Burial, ~~cremation~~ or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (Month) AUG 31 1948 (Signature) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29th 1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to Aug 28 1948 and that I last saw h alive on 8/26 1948

Immediate cause of death Hypertensive Cardiovascular Renal Disease — Duration 4 yrs
Due to Senility — 4 yrs
Due to
Other Conditions Chronic Myocarditis — 7 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Bahn
Address 2145 W Balto Date signed 8/30/48

VS 150

6654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G66354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 N Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 N Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma M Redford

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nathan H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1905

8. AGE: Years 43 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Honoza Valdivia
13. Birthplace Cuba

MOTHER
14. Maiden Name Mary N Heller
15. Birthplace Baltimore Md

16 (a) Informant Nathan H Redford
(b) Address 1304 N Belvedere Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Nathan Goldberg
(b) Address 1214 E Cold St

19 AUG 31 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 29 1948, and that I last saw her alive on Aug 25 1948.

Immediate cause of death: Carcinoma of Cervix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which)
(e) Means of injury

23. Signature Edwin G. Harrison M.D.

Address 7051 Oakland Date signed 8/30/48

66355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 N. Eutaw St
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacque Louis M. Bartlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1938

8. AGE: Years	Months	Days	If less than one day
10	7	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James C Bartlett
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnes Durkin
15. Birthplace Baltimore Md

16 (a) Informant James C Bartlett
(b) Address 300 N Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto. Md.
Funeral director Wm Cook Inc.
Address 217 St. Paul st

AUG 31 1948 (Date rec'd by registrar) (Signature of funeral director or person acting as such)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948, at 1 1/2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracrania hemorrhage

Due to

Other Conditions congenital spastic idiot

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-29-48

VS 181

53:56

AB-97018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 D

Registered No. 666356

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1 West Kenwood Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) FULL NAME Carl Frederick Saylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept-24- 1882

8. AGE: Years: 65 Months: 11 Days: 4 If less than one day: hr. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER

12. Name: Benjamin F. Saylor

13. Birthplace: Pa.

MOTHER

14. Maiden Name: Anna Shober

15. Birthplace: Pa.

16 (a) Informant: Records-Baltimore City Hospitals

(b) Address: 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: 9/1/48 (month) (day) (year)

(c) ~~Cemetery or~~ crematory: Green Mount

Location: Balto. Md.

18 (a) Funeral director: The Sollers

(b) Address: 27 E. Fayette St.

19 AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 2.45 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1945 to 8-28- 1948, and that I last saw him alive on 8-28 1948.

Immediate cause of death: Pulmonary edema

Due to: Hypertensive Cardiovascular disease

Due to:

Other Conditions: Syphilis known treated (include pregnancy within three months of death)

Date of operation:

Major findings of operation:

of autopsy: Dr. Schnur

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: William H. Kirkley

Address: Balt. City Hosp. Date signed: 30 Aug 48

6657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

666657
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution:
Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLOTTE MAUDE SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, Married, Widowed, Divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) February 25, 1867

8. AGE: Years	Months	Days	If less than one day: hr	min
81	6	4		

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry David Schmidt
13. Birthplace Unknown

MOTHER
14. Maiden Name Matilda H. (Unknown)
15. Birthplace Unknown

16 (a) Informant Calvin H. Yerby
(b) Address 2623 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) AUG 31 1948 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 2 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury a M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? What kind?
(d) Means of injury

23. Signature Emil L. Rogers M.D.
Medical Examiner
Date signed 8-30-48

VS 151

6358

ES102540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. 666658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 N. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Charles Nitchick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: XXXXX Aldia (nee Goulek)

6 (c) If alive, give age years

7. Birth date of deceased: mo. day yr Jan. 1, 1883

8. AGE: Years 65 Months 7 Days 27 If less than one day hr min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Nitchick
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Hardtwick
15. Birthplace Germany

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (c) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 19 48 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 19 46 to 8-28 19 48 and that I last saw him alive on 8-28- 19 48

Immediate cause of death: Bronchopneumonia, rt. lower lobe — Duration 24 hrs

Due to

Due to

Other Conditions arteriosclerosis, generalized, severe. — 10-20 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vickers M.D.
Address Balto City Hosp Date signed 28 Aug 48

VS 150

65:59 BC-48a 18347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. 66653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Ann DeNeal

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years	Months	Days	If less than one day
		1	20 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation N' Born Infant

11. Industry or business

FATHER
12. Name Jerry DeNeal
13. Birthplace Va

MOTHER
14. Maiden Name Gloria Chambers
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Gloria DeNeal
(b) Address 1416 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Cooksville Md
Location Md

18 (a) Funeral director George G. Wilson
(b) Address 130 Presstman St

19 AUG 31 1948 Huntington Williams (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 11 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 8/29 1948, and that I last saw h alive on 8/29 1948

Immediate cause of death	Duration
Shock	
Due to Heat Stroke?	
Due to Excessive atmospheric temperature.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5560 BC-B 21806

AB-122505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666560

157a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Diggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22-1945

8. AGE: Years	Months	Days	If less than one day: hr.	min.
3	5	7		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Diggs
13. Birthplace Va.

MOTHER
14. Maiden Name Cleo Ashby
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Hadaad
(b) Address 1631 Druid Hill Ave.

19 AUG 31 1948 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29- 1948, at 1.23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-48 1948, to 8-29- 1948, and that I last saw her alive on 8-29- 1948.

Immediate cause of death: Diarrhea with marked hypoproteinemia — Duration: 1 da.
Due to: Organism unknown
Due to:
Other Conditions: 1) Osteogenesis imperfecta 3 yrs. 2) Hydrocephalus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William P. Kean M.D.
Address Baltimore City Hosp. Date signed Aug 30, 48

VS 150

120a

6661 b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 66630 1

Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2540 Mace Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2540 Mace Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1867

8. AGE: Years 81 | Months 4 | Days 15 | If less than one day: hr. min

9. Birthplace Rockville, Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name UKNOWN
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace UNKNOWN

16 (a) Informant Mrs. Rebecca Reddick
(b) Address 5718 Lawton Street Detroit #8, Mich.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Baltimore, Maryland.
Location

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1947 to Aug 28 1948 and that I last saw h alive on

Immediate cause of death Cardiac Renal Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. A. J. Leonard
Address 2529 Joseph St. Date signed Aug 31 1948

VS 150

63662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 1[illegible]2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4615 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4615 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John A. MEAgher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife EUNice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. 1 min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bureau Receipts
11. Industry or business

FATHER	12. Name	John MEAgher
	13. Birthplace	BALTimore
MOTHER	14. Maiden Name	?
	15. Birthplace	BALTimore

16 (a) Informant Eunice Meagher
(b) Address 4615 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director L. C. Harle
(b) Address 1218 West St

19 (a) AUG 31 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948, at 11[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1941 to Aug 26 1948, and that I last saw h[illegible] alive on Aug 26 1948.

Immediate cause of death Coronary Occlusion — Duration 1 hr

Due to Coronary Disease — 7 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Fitzgibbons
Address 1214 Madison Ave Date signed 8/31/48

VS 139

3363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G66363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY CLAY MARTIN, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Emma A. Chesney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 16, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	13	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Fire Department

FATHER
12. Name John Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Elmira Wilson
15. Birthplace Md.

16 (a) Informant Mr. Harry C. Martin, Jr.
(b) Address 318 Radnor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948 at 8:50pm

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 1948, to Aug 29 1948, and that I last saw him alive on Aug. 29 1948.

Immediate cause of death: Uremia.
Due to Arteriosclerosis
Chronic nephritis
myocarditis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Wotherspoon
Address 3614 N. Rum Rd. Date signed 8/31/48

VS 150

6364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666364
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Henrico
(c) City or town Richmond R.F.D. 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth C. Baber (Baber)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kemper W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 13 1876

8. AGE: Years 72 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace: Henrico Co. Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Clarke
13. Birthplace: Va.

MOTHER
14. Maiden Name: Edith Woody
15. Birthplace: ### Va.

16 (a) Informant: Mrs. Arthur B. Selph
(b) Address: 2905 Edmondson Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory: Oakwood Cemetery
Location: Richmond Va.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves

19 (a) AUG 31 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30th 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to Aug 30 1948, and that I last saw h[illegible] alive on Aug 29 1948.

Immediate cause of death: Cerebral Haemorrhage — Duration: 1 day

Due to Generalized arterio sclerosis with hypertension.

Due to arterio sclerotic type heart disease with hypertrophy.

Other Conditions Myocardial insufficiency and congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature W. Michel M. D.

Address 2901 Edmondson Ave Date signed Aug 30 1948

VS 150

5365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66636 5

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 N Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 N Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Goebel

3 (b) If veteran, name war NO
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1860

8. AGE: Years 88 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Goebel
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma Linnemann
15. Birthplace England

16 (a) Informant Jack W. Goebel
(b) Address 2304 Greenmount Ave

17 (a) Final disposition (Burial, cremation or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1311 E Oak St

19 (a) AUG 31 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Aug 1948 to 29 Aug 1948, and that I last saw him alive on 29 Aug 1948.

Immediate cause of death	Duration
Dehydration	24 hrs
Due to Bronchopneumonia, bilateral	+ 2 days
Due to	
Other Conditions Advanced arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred B Goebel M. D.
Address 2843 St. Paul. Date signed 31 Aug 48

VS 150

6366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66366
Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3541 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Irene Garrison

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Roy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 4 1880

8. AGE: Years 67 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Garner
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Mollie Simmons
15. Birthplace Carroll Co Md

16 (a) Informant Mildred Keough
(b) Address 3541 Greenmount Ave

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof 9/2/48
(month) (day) (year)
(c) Cemetery or crematory Greenmount Md
Location Baltimore Co

18 (a) Funeral director Nathan Gold Co
(b) Address 1317 E Fayette St

19 (a) AUG 31 1948
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1947 to Aug 30 1948 and that I last saw her alive on Aug 29 1948.

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, or place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. North Ave (Date signed 8-31-48)

Correct age in years must be entered in this column

VS. 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. White.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Milton N. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 3, 1874

8. AGE: Years	Months	Days	If less than one day
74	5	26	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Indianna Mantley
15. Birthplace Va.

16 (a) Informant Miss Mattie F. White
(b) Address 434 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug 26 1948 and that I last saw her alive on Aug 28 1948

Immediate cause of death: Cardio Vascular Renal Disease — Duration ?

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1143 Linden Ave W Date Aug 31 48

VS 150

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66368

BC-C 55625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 Mt. Olivet Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeffrey Douglas Weal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1946

8. AGE: Years 1 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Weal
13. Birthplace Md.

MOTHER
14. Maiden Name Kathryn Stotler
15. Birthplace Miss.

16 (a) Informant George Weal
(b) Address 124 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28/48. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 46 to 8/28 19 48 and that I last saw h alive on 8/19 19 48

Immediate cause of death: Undetermined — Duration

Due to: Has been Chronically ill since birth. —

Due to:

Other Conditions: Clasping Goitre. Fibrosis of Pancreas (Include pregnancy within 3 months of death) — Births

Date of operation

Major findings of operation:

of autopsy: Cerebral Edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson Gantt M. D.
Address 4E. 33rd St. Date signed 8/31/48

Howard J. Madgic, M.D. over

correct age is especially important. Physician: please write the cause of death clearly, using

6369 Wal 2 S

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

Registered No. G66369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Cagel Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Jones
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	~~White~~ Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-28-87

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61 60	2	28		

9. Birthplace Mo. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Scott Jones
13. Birthplace Va

MOTHER
14. Maiden Name Mary Thomas
15 Birthplace Mo

16 (a) Informant J. D. D.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30th 1948 (month) (day) (year)
(c) Cemetery or crematory Father Dietz Cemetery
Location St Helena Md.

18 (a) Funeral director Bloxom & Dean
(b) Address 1000 Brantley.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Practitioner for Wallace M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1948 at 1237 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23- 1948 to 8-25 1948 and that I last saw him alive on 8-25 1948

Immediate cause of death Cerebral Accident — Duration

Due to Carcinoma of Tonsil — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr 26, 1948

Major findings of operation: Carcinoma Tonsil

of autopsy: Radical neck dissection

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Handelsman M. D.
Address Johns Hopkins Hosp Date signed 8-25-48

VS 180

66370 ✓ G66370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Forrest St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ethel Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 5, 1892

8. AGE: Years	Months	Days	If less than one day
56	1	23	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Chadwick Brown
13. Birthplace

MOTHER
14. Maiden Name Nancy Poole
15 Birthplace

16 (a) Informant Daniel Johnson (son)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Elroy O Welsh
(b) Address Granite Quincy Mass

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Burial permit issued at Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1948 at 6:50 A.M

21. I certify that death occurred on the date above stated: that I attended deceased from 8-26-1948 to 8-28-1948, and that I last saw her alive on Aug 28, 1948

Immediate cause of death Cardiac Failure — Duration 5-7 days

Due to Hypertensive C.V. renal disease — years

Due to Essential hypertension — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Li Pira C.F. Judd M.D. M. D.
Address Mercy Hospital Date signed 8-28-48

X

371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

✓ G66371 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Gwynns Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 83-2-28

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Laura Demuth

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ Charles H. Demuth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1865

8. AGE: Years 83 | Months 2 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Depser
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Witzgall
15. Birthplace Germany

16 (a) Informant Mrs. Lillie E. Broessel
(b) Address 3019 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (d) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH August 28, 1948, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug 1948 and that I last saw h[illegible] alive on Aug 15 1948.

Immediate cause of death	Duration
Arteriosclerosis Cardio-vascular disease	10 yrs
Due to Decubitus ulcer & sepsis decubitus	3 mos
Due to Senile dementia	7 yrs
Other Conditions Prostatitis	7 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1435 Gwynns Falls Pkwy Date signed 8/31/48

VS 150

correct age is especially important. Physicians, please write distinctly.

6372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 666372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hr. 20min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. WHITMORE

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0762

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Armin Whitmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30, 1897

8. AGE: Years	Months	Days	If less than one day
51	6	30	hr. min.

9. Birthplace Gadsden, Alabama (Town, county, and state)

10. Usual Occupation Insulation Mechanic

11. Industry or business Chamberlin Co.

FATHER
12. Name Alex Whitmore
13. Birthplace Alabama

MOTHER
14. Maiden Name Cora Hogue
15. Birthplace Alabama

16 (a) Informant Mrs. Armin Whitmore
(b) Address 1609 Longwood St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) AUG 31 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/29/48 at ? M.
(b) Where did injury occur? 1609 Longwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury four burners on on stove

23. Signature Earl W. Bruns, M.D. Medical Examiner
Date signed 8/30/48

G666373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G666373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 S. Madeira Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Madeira Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Katherine Zysk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank Zysk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Podlesny
13. Birthplace Poland

MOTHER
14. Maiden Name Leonora ?
15. Birthplace Poland

16 (a) Informant Mrs. Frances Gos
(b) Address 413 S. Madeira Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John J. Welsh
(b) Address 401 S. Chester Street

19 (a) AUG 31 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2.16

20. DATE OF DEATH Aug. 29, 48 19 , at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1945 to Aug 29 1948, and that I last saw her alive on Aug 29 1948.

Immediate cause of death: ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration 1/23/45

Due to

Due to

Other Conditions UMBILICAL HERNIA — ???

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Beth F. Arenza M. D.

Address 207 E. Chester St Date signed 8/30/48

VS 3

Correct age is especially important.

66574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 666574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Rosedale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Rosedale Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice M. Kutner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Heyman
13. Birthplace Russia

MOTHER 14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Ethel Kutner
(b) Address 3411 Rosedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Location Owings Mills Road

18 (a) Funeral director Frederick Keeney Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1948, at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to 8/30 1948, and that I last saw him alive on 8/30 1948

Immediate cause of death: Carcinoma of lung with metastases — Duration: 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton B. Kirsh, M.D.
Address 2330 Eutaw Pl. Date signed 8/30/48

VS 150

6375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 666375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Auchentorly Ter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE GREENSPAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Saul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 Months Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kettle
13. Birthplace Lith

MOTHER
14. Maiden Name Totee
15. Birthplace Lith

16 (a) Informant Ellis Kallert
(b) Address 3500 Auchentorly Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) Filed by Huntington Williams M.E. (Registrar) Baltimore
(b) Date received by Registrar AUG 31 1948

VS- 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-48 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-48 1948 to 8-30 1948, and that I last saw h[illegible] alive on 8-30 1948.

Immediate cause of death: UREMIA — Duration

Due to: Renal Arteriosclerosis

Due to:

Other Conditions: Arteriosclerotic H.D

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Korf M. D.
Address Sinai Hosp. Date signed 8-30-48

correct as recorded in this office. Important. Please write plainly. Use pen and ink.

6376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 666376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3428 Hickory Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas A. Morrow.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 4 1940

8. AGE: Years	Months	Days	If less than one day
8	5	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Thomas A. Morrow Jr.
13. Birthplace Va

MOTHER
14. Maiden Name Loreen E. Humphreys
15. Birthplace N. C.

16 (a) Informant Thomas A. Morrow Jr.
(b) Address 3428 Hickory Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Paul E. & Kenneth Jones
(b) Address 3615-17 Lakestreet Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Pimlico for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Aug 29 1948 and that I last saw him alive on Aug. 29 1948.

Immediate cause of death Carcinomatosis — Duration

Due to Sarcoma of Thymus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F. Glassman M. D.
Address 4037 Gallis Rd. Date signed 8/31/48

VS 150

66377

AB-122354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13

G66377

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 903 Boyd St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9- 1928

8. AGE: Years	Months	Days	If less than one day
20	5	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Nathaniel Lee

13. Birthplace Md.

MOTHER 14. Maiden Name Elnora Floyd

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 1, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St.

19 AUG 31 1948 Huntington Williams Reg.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 1948 at 11.15 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23- 1948 to 8-28- 1948, and that I last saw h im alive on 8-28- 1948.

Immediate cause of death	Duration
Tuberculous meningitis	2 weeks
Due to	
Due to	
Other Conditions Tuberculous adenitis Tuberculous pleural effusion	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret A. Morgan M. D.

Address Balt. City Hosp. Date signed 8-30-48

VS 193

X

5378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G666378 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 N. Stockton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Shannanhause Joshuaway.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Benjamin Joshuaway.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 13, 1895.

8. AGE: Years 53 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace A. A. County, Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Shannanhause
13. Birthplace Elizabeth City, N.C.

MOTHER
14. Maiden Name Lilly Carter
15. Birthplace Gloucester Co. Va.

16 (a) Informant Rose Johnson
(b) Address 116 N Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 32[illegible] Pennington Avenue

19 (a) AUG 31 1948 (b) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948 to 8-28 1948 and that I last saw h[illegible] alive on 8-27 1948.

Immediate cause of death: Cerebral Hemorrage — Duration: 1 hr

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 6[illegible] Date signed 8-31-48

VS 150

Caution: It is a misdemeanor for any person to willfully make any false statement in this certificate.

66379 La 4005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

✓ 666379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid 88
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1003 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Tucker Samuel Tucker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/84

8. AGE: Years 64 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Odessa Del (Town, county, and state) None

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Jennie Anderson
(b) Address 1003 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 822 N. Edmondson Ave

19 (a) AUG 31 1948 (b) Washington Memorial Park
(Date rec'd by registrar) (Registration No.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/27 1948 and that I last saw h[illegible] alive on 8/27 1948.

Immediate cause of death Uremia
Due to Chronic Interstitial Nephritis
Due to Arterial Sclerosis
Other Conditions Structure

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm or place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 8/30/48

VS 150

Edward Walden ×

correct age is especially important. Physicians, please write the causes of death plainly.

66380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital DOA 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 870 W. Fairmount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD GASTON Ernest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Bessie Gaston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Beatrice Harper
(b) Address - Jessup Station, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 2, 1948

(c) Cemetery or crematory: Mt. Auburn Cem
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address 322 N. Pennsylvania Ave

19 (a) AUG 31 1948 (Date rec'd by registrar) (b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rose M.D.
Medical Examiner
Date signed 30 Aug 48

VS 151

6381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 124 B

Registered No. 66381

CERTIFICATE CORRECTED 3-17-54

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES LAYFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No. 182-03-7052

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Ruth Layfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16. 1910

8. AGE: Years 38 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Salisbury Md (Town, county, and state)

10. Usual Occupation Helper Truck Driver

11. Industry or business Globe Brewery

FATHER
12. Name Geo. J. Layfield
13. Birthplace Salisbury

MOTHER
14. Maiden Name (Ellen Knobel) HELEN M. NOBLE
15. Birthplace Salisbury

16 (a) Informant Mr. Raymond Layfield
(b) Address Randallstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof
(c) Cemetery or crematory Fpk M.E. Cemetery
Location Fpk Md

18 (a) Funeral director A.E. Arthur
(b) Address Fpk Md

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Washington 16 Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 1:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart.
Acute edema of lungs.
Due to Fatty degeneration of Liver.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/28/48

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66382 ✓ 191 — Registered No. G66382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Lancaster (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME STEPHEN CIAPURA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER 12. Name J. Ciapura

13. Birthplace Lithuania

MOTHER 14. Maiden Name Unk.

15. Birthplace

16 (a) Informant Frances Ciapura

(b) Address 1707 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day)

(c) Cemetery or crematory Sacred Heart of Mary

Location Baltimore

18 (a) Funeral director Fred W. Ozazewski

(b) Address 1930 Eastern Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington for Baltimore, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/48 19 , at 1049 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Lewis M.D. (Medical Examiner.)

Date signed 8/29/48

X

66383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Wyanoke Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Wyanoke Ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Kisling Kisinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Adolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Frank Kruzykowski
13. Birthplace Poland

MOTHER 14. Maiden Name Baus
15. Birthplace Poland

16 (a) Informant Caroline Kisling
(b) Address 520 Wyanoke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1934 Eastern Ave

19 Aug 31 1948 (Date received by Registrar) (Wm Washington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1948, to Aug. 29, 1948 and that I last saw h[illegible] alive on Aug. 29, 1948

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Coronary Sclerosis — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/30/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1866

666384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St. Balto, Md.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4 7
(e) Length of stay in Baltimore (yrs., mos., or days) 82 10 23 Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Thomas Solomon.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Emma Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 6, 1865

8. AGE: Years	Months	Days	If less than one day
82	10	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Benjamin D. Solomon,
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Ruth Hamilton
15. Birthplace Unknown

16 (a) Informant A. Lake
(b) Address 700 W. 40th St, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1948 (month) (day) (year)
(c) Cemetery or crematory Green mount
Location Balto md

18 (a) Funeral director Henry H. Jenkins Sons Funeral Home
(b) Address 490 5 Huntington Ave Huntington Williams Md

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948. at 12:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1940. to 8/29 1948. and that I last saw him alive on 8/28 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 3 years
Due to Generalized Arteriosclerosis — 15 years
Due to Bilateral Pneumonia — 5 days
Other Conditions Hypostatic Pneumonia Fracture Neck of Femur (Left) (3 Weeks) — 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 8 at 3:45 PM
(c) Where did injury occur? 700 W. 40th St. Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home For Incurables While at work? No (Specify type of place)
(e) Means of injury fell on lawn while walking

23. Signature W. Grafton Prosperi
Address 14 Medical Arts Bldg. Date signed 8/29/48 M. D.

Howard J. Maddux, M.D.

VS 153

66385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

Registered No. G666385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or institution: St. Joseph's 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23/4 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 3728 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs. Caroline W. Thomas Kehoe~~ (CAROLINE W. KEHOE)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-0962

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Thomas Jos. Kehoe

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1902

8. AGE: Years 45 | Months 9 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Wife.

11. Industry or business Own home

FATHER
12. Name JOHN JANNUSCH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANNA K. SMITH
15. Birthplace BALTIMORE, MD.

16 (a) Informant THOMAS J. KEHOE
(b) Address 3728 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM. Location EASTERN AVE.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) AUG 31 1948 ~~Washington, Maryland~~ (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29, 1948, to Aug. 29, 1948, and that I last saw h er alive on Aug. 29, 1948.

Immediate cause of death Heat Stroke — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Right hemiplegia of 48 hours duration. Cerebral thrombosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Gay C. Parsons Jr. M.D.
Address 901 S. Conkling St. Date signed 8/29/48

PHYSICIAN
Underline the cause to which death should be charged and tabulate

VS 150

66386 Csl 2
28828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 13 B

G66386 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 N Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Othelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-6-10

8. AGE: Years	Months	Days	If less than one day
37	8	22	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER 12. Name Jesse Brown
13. Birthplace Va

MOTHER 14. Maiden Name Ossie Carey
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory Location Charlottsville Va.

18 (a) Funeral director Mrs Robert A. Ellis & Son
(b) Address 1129 N. Carlin's St.

19 AUG 31 1948 (a) Signature of Registrar Huntington Williams Registrar
(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26, 1948, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945 to 8-26 1948 and that I last saw h.. alive on 8-26 1948.

Immediate cause of death	Duration
Probable Pulmonary Embolus	1 min
Due to Tuberculosis	5 mo.
Due to Tuberculous Pneumonia	1 mo.
Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/26/48

VS 150

66387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66387

1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town MIDDLE RIVER.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 BANK COURT, VICTOR VILLA
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK MARSHALL MERRITT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 28 1936

8. AGE: Years 11 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace KENTUCKY. (Town, county, and state)

10. Usual Occupation SCHOOL BOY.

11. Industry or business

FATHER
12. Name MR STANLEY MERRITT.
13. Birthplace KENTUCKY.

MOTHER
14. Maiden Name EVA COY.
15. Birthplace KENTUCKY.

16 (a) Informant EVA C. MERRITT.
(b) Address 4 BANK COURT, BALT, 20, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept (month) (day) 48 (year)

(c) Cemetery or crematory Location Lexington — Kentucky

18 (a) Funeral director Grand F. Seitz
(b) Address 3142436 St

19 (a) AUG 31 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 31 1948. at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 12 1948. to AUG 31 1948. and that I last saw him alive on AUG 30 1948.

Immediate cause of death CONGESTIVE HEART FAILURE. — Duration 19 d.

Due to CHRONIC GLOMERULO-NEPHRITIS — 2 yrs.

Due to

Other Conditions UREMIA HYPOCALCEMIA. — 1 mon.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William E. Cleaver M.D.
Address Union Mem Hosp Date signed 8-31-48

VS 180

666588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 666588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ballo
(c) City or town Sparks (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abram L. Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Novella Dickson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1879

8. AGE: Years	Months	Days	If less than one day
69	6	11 10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Asa Phillips
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. A. L. Phillips
(b) Address Sparks, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48
(c) Cemetery or crematory Douglas AME
Location Cockeysville, Md.

18 (a) Funeral director L. M. Brooks
(b) Address Sparks, Md.

19 (a) AUG 31 1948 (Date received and registered) (b) Hunting for Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royston M.D.
Medical Examiner
Date signed 8/31/48

VS 191

66389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1148 Ward St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1148 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE L. BENTZ GUBITOSE-ROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife No record.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30th-1892

8. AGE: Years 55 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Geo. Bentz
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Sallie Howe
15. Birthplace Md.

16 (a) Informant John H. Benges
(b) Address 1148 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Lenburnie, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 31 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28th 1948, at 10 35 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH myocardial degeneration

Due to

Other Conditions obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Roy M.D. Medical Examiner.
Date signed 8/29/48

VS 151

G66390

ES-107010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G66390 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals, 201
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 8 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Hausman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Mansdorfer
15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Westwood
Location Baltimore

18 (a) Funeral director Fitzpatrick & Gode
(b) Address 1708 W. Lombard St.

19 AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH 8-29 1948 at 5:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 12-21 1946 to 8-29 1948, and that I last saw him alive on 8-29 1948.

Immediate cause of death: Probable rupture of aortic aneurysm — Duration

Due to Luetic Cardiovascular Disease

Due to

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wellington H. Hunter M.D.
Address Balto City Hosp Date signed 30 Aug 48

Please write clearly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15

66391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 666391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 2 18
(e) Length of stay in Baltimore (yrs., mos., or days) abt 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City of Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Park Ave -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Reguard

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward L. Reguard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1865

8. AGE: Years 82 83 | Months 3 8 | Days 16 14 | If less than one day hr. min.

9. Birthplace Brunswick-Germany
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry M. Iler - (?)
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Edward F. Reguard (Son)
(b) Address 1921 Park Ave - City

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore -

18 (a) Funeral director Stewart & Mower Company
(b) Address 108 - West North Ave - City

19 (a) AUG 31 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1948, to Aug 31 1948, and that I last saw h[illegible] alive on 28 aug. 1948.

	Duration
Immediate cause of death: Arteriosclerotic Hypertensive cardiovascular disease with cardiac failure	5 years +
Due to	
Due to	
Other Conditions: Carcinoma of Bladder	1yr +

(Include pregnancy within 3 months of death)

Date of operation April 48

Major findings of operation: Carcinoma of Bladder - Transplantation of ureters

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Gradwohl, M. D.
Address 20 E. Preston St - Date signed 31 Aug 48

VS 150

correct age is especially important. Physicians: please write the cause of death plainly, and report

G66392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 E. 25th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. 25th Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No) If yes, name country -------

3 (a) FULL NAME GENEVIEVE L. WHITEFORD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 67	--	--	-- hr. --- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Whiteford
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Riley
15. Birthplace Maryland

16 (a) Informant W. Hamilton Whiteford
(b) Address Title Bldg. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. H. Ulman and Son
(b) Address 905 N. Calvert St.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Aug 30 1948, and that I last saw her alive on Aug. 23 1948.

Immediate cause of death: Hypertensive arteriosclerotic cardiovascular disease — Duration: 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Iranger M.D. M.D.
Address 1402 E. Lanvale St. Date signed 8/30/48

VS 150

G66393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G66393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4737 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4737 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Dunn

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-12-4441

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 7, 1878

8. AGE: Years 70 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Laundry Foreman

FATHER
12. Name Samuel J. Dunn
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Carlyle
15. Birthplace England

16 (a) Informant Mrs. Lucille Dunn
(b) Address 4737 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (Month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Byers
(b) Address 5005 Park Heights Ave

19 (a) AUG 31 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 9:57 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1948, to August 29 1948 and that I last saw h[illegible] alive on Aug 29 1948.

Immediate cause of death: Carcinoma of Liver — Duration: 3/6/48

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Bullet M. D.
Address 1003 Park Heights Ave Date signed 8/31/48

VS 150

66394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66394

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4020 Lewiston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4020 Lewiston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Edna Andrews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	W.

6 (b) Name of husband or wife Harry G. Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1886

8. AGE: Years	Months	Days	If less than one day
62	3	19	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton Hood
13. Birthplace Maryland

MOTHER
14. Maiden Name Mozie Glascock
15 Birthplace Ky.

16 (a) Informant Mrs. Harry G. Andrews
(b) Address 4020 Lewiston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Loring Bryan
(b) Address 5005 Park Heights Ave

19 (a) Aug 31 1948 (b) Huntington, Md.
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 11 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 29 1948
and that I last saw her alive on Aug 29, 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius C. Bleich M. D.
Address 5356 Reisterstown Rd Date signed 8/30/48
No X

VS 199

66395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66395
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Cedarwood Rd. Catonsville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Caton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 17, 1888

8. AGE: Years 59 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Mental nurse Man

11. Industry or business

FATHER 12. Name Michael J Caton (dead)
13. Birthplace Md

MOTHER 14. Maiden Name Anne Conner (dead)
15. Birthplace Md

16 (a) Informant Lillian E. Caton
(b) Address 14 S. Cedarwood Rd.

17 (a) Burial (b) Date thereof 9-2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore Md. Fayette St.

19 (a) SEP 21 1948 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 1 E.S.T. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1948 to 8/29 1948 and that I last saw h alive on 8/29 1948.

Immediate cause of death Myocardial infarction, acute
Due to pulmonary edema, complete heart block
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank H Mayer Jr. M.D.
Address St Agnes Hosp Date signed 9/1/48
Balto Md

VS 150

G66396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G66396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2546 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Corrigan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George W.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) March 17, 1885

8. AGE: Years: 63 | Months: 6 5 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: John J. McCumber
13. Birthplace: Penn.

MOTHER
14. Maiden Name: Anna Price
15. Birthplace: Penn.

16 (a) Informant: George W. Corrigan
(b) Address: 2546 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: George A. Farley
(b) Address: Edmondson Ave & Fayette St.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Aug 29 1948, and that I last saw her alive on Aug 28 1948.

Immediate cause of death: Pulmonary Oedema — Myocarditis
Due to: Arteriosclerosis Dementia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Huston L. Mitchell
Address: 2557 Wilkens Ave Date signed: 8/31/48 M. D.

G66397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 Hillen Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 40 Months Days If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER | FATHER

12. Name unknown

13. Birthplace " "

14. Maiden Name Adell Dennis

15. Birthplace Canada

16 (a) Informant Frances Mitchell

(b) Address 301 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elrod & Wilson

(b) Address 1001 Bradley ave

19 (a) AUG 31 1948 (b) Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948 at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Myocardial Degeneration

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner

Date signed 29 Aug 48

VS 151

666398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 666398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Jefferson ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Jefferson ST
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE YARBROUGH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Henry Yarbrough
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1897

8. AGE: Years	Months	Days	If less than one day
50	11	24	hr. min.

9. Birthplace Wake Forest N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rev. Clemens Dunn.
13. Birthplace Wake Forest N. C.

MOTHER
14. Maiden Name Mary J. Dunn
15. Birthplace Louisburg N. C.

16 (a) Informant Henry Yarbrough
(b) Address 1202 Jefferson St.

17 (a) Burial (b) Date thereof Aug 31-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy S. Wilson
(b) Address 1001 Baltimore Ave

19 AUG 31 1948 (b) Investigator
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1948, to 7-25 1948, and that I last saw her alive on 7-25 1948.

Immediate cause of death CARCINOMATOSIS — Duration 6 mo 2 wks

Due to CARCINOMA of BREAST

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St Date signed 8-30-48

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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666399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-A
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1st yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIE JENKINS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years: 47 (est) | Months | Days | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name John Jenkins
13. Birthplace N. C.

MOTHER 14. Maiden Name Jennie Edwards
15. Birthplace N. C.

16 (a) Informant Mildred Jenkins
(b) Address 613 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury ave Huntington Woods Md

19 (a) AUG 31 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 48, at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 28 Aug 48

VS 151

6400 JL - 59196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 Registered No. 66400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sister of the Poor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Lynch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Lynch (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 29, 1867

8. AGE: Years	Months	Days	If less than one day
81	5	29	hr. min

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hugh McVeigh
13. Birthplace Scotland

MOTHER
14. Maiden Name Catherine Noonan
15. Birthplace Balto, Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Long Green, Md.
18 (a) Funeral director Charles L. Zeile
(b) Address 901 S. Conkling St.
19 (a) AUG 31 1948 Huntington Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1940 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death ? Coronary occlusion — Duration

Due to Arteriosclerotic Heart disease Fibrillation and failure

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David L. Marine M. D.
Address Balto City Hosps Date signed 8-31-48

VS 193

93D

66401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66401 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Chapel Gate Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? N. (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. KNABE

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John Knabe

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 10, 1877

8. AGE: Years 71 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Upton, Penna. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Neady
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. John Knabe
(b) Address 510 Chapel Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans Sons Inc.
(b) Address 16 N. Mt. Royal Ave

19 (a) Filed [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 2d 1948 to Aug 29 1948, and that I last saw her alive on Aug 29 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel G. Schwartz M.D.
Address 2320 Eutaw Place Date signed 8/31/48

VS, 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Brooklyn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Brooklyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith J. Philburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo. A.

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr) Dec 14, 1907

8. AGE: Years	Months	Days	If less than one day
40	8	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER 12. Name Robert Doran

13. Birthplace Md

MOTHER 14. Maiden Name Queenie Harrison

15. Birthplace Md

16 (a) Informant Mr. Geo. A. Philburn

(b) Address 3716 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ /48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Annapolis Blvd

18 (a) Funeral director John F. Kenny Inc

(b) Address 716 Light St

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Remington & Belvedere, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 3 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1947, to 8-30 1948, and that I last saw h alive on 8-30 1948.

Immediate cause of death: Chronic Myocardial Degeneration — Duration 8 yr.

Due to Rheumatic fever

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Sollod

Address 707 Font Ave. Date signed 8-31-48 M.D.

VS 15)

G66403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G66403
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County AA Co
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Hawkins St Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Logan Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Theona Tolmie

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) May 20, 1915

8. AGE: Years	Months	Days	If less than one day
33	3	11	hr. min.

9. Birthplace Ashland, Ky.
(Town, county, and state)

10. Usual Occupation Crain Operator

11. Industry or business Construction

FATHER
12. Name Charles N. Jackson
13. Birthplace Ky

MOTHER
14. Maiden Name Hazel Baer
15. Birthplace Ky

16 (a) Informant Mrs Charles Jackson
(b) Address 6400 Arundel Cove

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)

(c) Cemetery or crematory Ashland Cem
Location Ashland, Ky.

18 (a) Funeral director John F Feldmeyer Inc
(b) Address 7th Eight St Huntington West Va

19 (a) AUG 31 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31- 1948 at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25- 1948 to 8-31- 1948 and that I last saw him alive on 8-31-1948.

Immediate cause of death	Duration
Uremia	
acidosis	
Due to Chronic hemorrhagic nephritis	20 yr
Due to Hypertrophied arteriosclerosis	
Other Conditions Diabetes Mellitus Arteriosclerotic Heart Disease	20 yr

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
—
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature William T. Hearn M. D.
Address South Balti Hos Hosp Date signed 8/31/48

Baltimore 36, Md

VS 150

131C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or [redacted] St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Towson, Rural Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Immaculate Conception Convent
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Sr. Mary Hortense, O.S.F.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/26/73

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	11 10	4		

9. Birthplace Wilmington, Del. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name James Mc Donough
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Keenan
15. Birthplace Ireland

16 (a) Informant Mother M. Florinda O.S.F.
(b) Address St. Joseph Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) 9-1 1948 (Date received by registrar) Thurlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1948 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1948 to Aug. 30, 1948 and that I last saw her alive on Aug. 30, 1948

Immediate cause of death Myocardial Insufficiency — Duration

Due to Asteno-sclerotic Heart Disease

Due to Hypertensive Cardio-vascular Disease

Other Conditions Cerebral Thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Persons Jr. M.D.
Address St. Joseph's Hospital Date signed 8/30/48

correct age is especially important. Typewrite or print plainly. Please write the space of each item.

VS 150

66405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 66405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 S. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie R. Dembinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife William Dembinsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1889

8. AGE: Years	Months	Days	If less than one day
59	4		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert S. Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant William Dembinsky
(b) Address 436 S. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave.

18 (a) Funeral director Henry J. Weikel
(b) Address 4101 Edmondson Ave.

19 AUG 31 1948 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948 to Aug 29 1948, and that I last saw h[illegible] alive on Aug 26/48.

Immediate cause of death Trauma — Duration 2 wks

Due to Chronic Nephritis — 20 Yrs

Due to

Other Conditions Hypertension, Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/31/48

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66406
AB-15911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Leser-or Frederick Lesser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-1-1873

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ? Martin Lesser
13. Birthplace ? Russia

MOTHER
14. Maiden Name Annie Maiser
15. Birthplace ? Russia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1/48. (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway A.A.Co.Md.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) AUG 31 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17- 1918, to 8-28- 1948, and that I last saw him alive on 8-28- 1948.

Immediate cause of death: Respiratory failure, Cerebral thrombosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rt. pulmonary congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Beckbold, M.D.
Address Balto City Hosp. Date signed 8-30-48

VS 150

66407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-3D

Registered No. 666407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:
Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Good Samaritan Nursing Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George WILLIAM SCHIMINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1889

8. AGE: Years	Months	Days	If less than one day
58	9	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Davis Coal & Coke Co.

FATHER
12. Name George C. Schiminger
13. Birthplace Md.

MOTHER
14. Maiden Name Emma B. Mainz
15. Birthplace Md.

16 (a) Informant Mrs. Emma Graham
(b) Address 3712 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2/48
(month)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave.
Huntington Mission, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertension C.J. Pneum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner

Date signed 8-31-48

VS 15t

66408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G66408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Coyle

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife William Coyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Carr
13. Birthplace

MOTHER 14. Maiden Name Catharine
15 Birthplace

16 (a) Informant Sarah Harvey
(b) Address 406 E Biddle St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Milligan Cook Inc
(b) Address 1917 St Paul St

19 SEP 1 1948 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948 at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Aug 30 1948, and that I last saw he alive on Aug 28 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	2 hrs
Due to Hyperthyroidism	3 yrs
Due to	
Other Conditions Myocarditis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Thompson M. D.
Address 723 N Patterson Pk Date signed Aug 31, 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66409

G6409 / X ✓ 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Berlona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 7107 Windsor Mill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORDELIA L. HILDEBRANDT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank M. Hildebrandt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd 1859

8. AGE: Years	Months	Days	If less than one day
89	7	27	hr. min.

9. Birthplace Howard Co. Maryland. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Andrew Timanus
13. Birthplace Baltimore Co Md.

MOTHER
14. Maiden Name
15. Birthplace Maryland.

16 (a) Informant F. M. Hildebrandt
(b) Address 198 Oakdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1st 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3801 Frederick Ave.

18 (a) Funeral director Phillips Timanus
(b) Address 4810 Liberty Heights Ave.

19 SEP 1 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Aug. 30th 1948, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1948 to Aug 30 1948 and that I last saw her alive on Aug 30 1948

Immediate cause of death — Duration
Chronic Myocarditis 1 day

Due to

Due to

Other Conditions Senile Senescence 5 yrs
& Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Richardson M.D.
Address 112 W. 20th St. Date signed Aug 30. 48

93d

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

IS-66410
Bal 138078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 209

Registered No. 66410

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Shakespear Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Keuhne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17- 1894

8. AGE: Years	Months	Days	If less than one day
53	11	26	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Edward Keuhne
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary McKenna
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Colored Dept. Location Germantown Rd.
18 (a) Funeral director Chas. Sparrow Sons
(b) Address 318 Light St.
19 (a) SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12- 1948; at 10.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1948 to 8-12 1948, and that I last saw him alive on 8-12- 1948

Immediate cause of death Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions Positive Serological test for Syphilis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm. T.B. & Cavitation-bilat.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Gaylord Burda M. D.
Address Baltimore City Hosp. Date signed 8/21/48

12/12

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G66411 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5019 Orville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Morris ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-37

8. AGE: Years 10 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Va (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Robert L. Morris
13. Birthplace Va

MOTHER 14. Maiden Name Frances Robinson
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)
(c) Cemetery or crematory Roanoke Va
Location same

18 (a) Funeral director Udell Funeral Home
(b) Address 2008 Orleans St

19 (a) Date rec'd by Registrar 9-1-1948 (b) Filed by Huntington Williams M.D. Registrar

VS 150 To approve Temporary Medical Examiner 9-2-48 M.D.

MEDICAL CERTIFICATION

35

20. DATE OF DEATH Aug 31 1948 at 9:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30-1948 to 8-31-1948 and that I last saw him alive on 8-31 1948

Immediate cause of death: Anaphylactic Reaction - (Horse Serum) — Duration
Due to Hypersensitivity to FOREIGN PROTEIN
Due to
Other Conditions Tetanus - Complication of Compound FRACTURE - Rt. FOREARM
(Include pregnancy within 3 months of death)
Date of operation Aug 12, 1948 Aug 30 1948
Major findings of operation: (1) Compound fracture Rt. Forearm (2) Postoperative infection
of autopsy:

PHYSICIAN: Underline the one which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 12 at 6 PM M
(c) Where did injury occur? 5019 Orville Ave. (City or town) Balto. (County) MD (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fell from tree

23. Signature John William Hellman M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

5412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE FELMER BOWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-5602

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Lottie M. Bowman
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) Feb 15 1888

8. AGE: Years	Months	Days	If less than one day
60	6	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business Maryland

FATHER
12. Name George Bowman
13. Birthplace Dale Md

MOTHER
14. Maiden Name Ella Monsell
15. Birthplace Boydton Va

16 (a) Informant Son
(b) Address 8618 Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2. 1948 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Md

18 (a) Funeral director Wm. Miles Wm. M. Miles & Son
(b) Address 5311 Edmondson Ave

19 SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 30, 1948 at 12 32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1948, to 8-30 1948, and that I last saw h I M alive on 8-30 1948.

Immediate cause of death Acute Pulmonary Edema and Right Cardiac Vascular Accident.

Duration

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema Left Ventricular Hypertrophy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place)
(e) Means of injury

23. Signature George P. Grove M.D.
Address Union Memorial Hospital Date signed 8/30/48

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

66413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 82a

Registered No. 66413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 N. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA VENEY HUGHLETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Separated

6 (b) Name of husband or wife Clifton Hughlett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	29 27	hr. min.

9. Birthplace Westmoreland, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nelson Smith

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Smith

15. Birthplace Virginia

16 (a) Informant Frank R. Veney-Son

(b) Address 430 E. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location Arbutus, Md.

18 (a) Funeral director Charles L.

(b) Address 802 Madison Ave.

19 (a) SEP 1 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 8-29 1948 and that I last saw her alive on 8-29 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Coronary Thrombosis	
Due to Arteriosclerosis	
Other Conditions Gastro Enteritis Probable	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature Jas. Anderson M. D.

Address 612 Edmondson Ave. Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

5814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. 666414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Westwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Westwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA BELL HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Charles Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 4, 1881

8. AGE: Years	Months	Days	If less than one day
67	3	26	hr. min.

9. Birthplace King George County, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isiah Wilkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Wilkins
15. Birthplace Virginia

16 (a) Informant Charles Hall
(b) Address 1723 Westwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles F. Law
(b) Address 882 Madison Ave

SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1948 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/30 1948 and that I last saw her alive on 8/26 1948.

Immediate cause of death Carcinoma of Breast
Due to C Generalized metastasis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 y
2 m.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature J. Preston Grant
Address 601 N. Carroll Ave Date signed 8/31/48 M.D.

G66415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G66415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 159 days
(e) Length of stay in Baltimore (yrs., mos., or days): 159 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County: New York
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 105 Broad St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: OWEN TULLER ROWE

3 (b) If veteran, name war: ?
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4, 1893

8. AGE: Years: 55 | Months: 2 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Columbus, Ohio (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Seafarer

FATHER
12. Name: Grant Rowe
13. Birthplace: ?

MOTHER
14. Maiden Name: Olive Tuller
15 Birthplace: Columbus, Ohio

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 1-48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem. Baltimore County
Location: York Road

18 (a) Funeral director: Huntington Williams
(b) Address: 403 E. 25th St.

19 SEP 1 1948 (Date rec'd by registrar) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23 1948 to Aug. 29 1948, and that I last saw h im alive on Aug. 29 1948.

Immediate cause of death: 1- Peritonitis of unknown etiology with intestinal obstruction, partial — Duration: Several mos.

~~Due to~~:
2- ~~Gastric ulcer~~ Adenocarcinoma of stomach — Duration: 6 mos.

Due to: ulceration or ulcer, chronic, gastric & carcinoma — Duration: ?

~~Other Conditions~~:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 8/30/48

VS 150

66416 BC-C 99324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66 B

Registered No. 66416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hrs. 35min.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo. 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME VIRGINIA LEE BOESCHE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 23, 1947

8. AGE: Years	Months	Days	If less than one day
—	8	8	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name CHARLES ROBERT BOESCHE
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name LOLA BRUGGMAN
15. Birthplace Churchville, Md.

16 (a) Informant Parents Charles R. Boesche
(b) Address 3014 Ellerslie Ave, Baltimore 18, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Frederick Ave

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 6209 Harford Road

SEP 7 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 4 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1948 to Aug. 31, 1948, and that I last saw h[illegible] alive on Aug. 31, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	?
Due to hypocalcemia	
Due to —	
Other Conditions Jaundice of unknown eliology. (Include pregnancy within 3 months of death)	9 Days

Date of operation —
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Union Memorial Hosp. Date signed Aug 31, 1948

VS 153

X

66417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. 66417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/86

8. AGE: Years	Months	Days	If less than one day
62	7	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr Nelson Dare
13. Birthplace Md

MOTHER
14. Maiden Name Miss Evelyn Cates
15. Birthplace Md

16 (a) Informant Daughter
(b) Address 900 Mod ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location W. Halstead

18 (a) Funeral director W. Halstead
(b) Address 916 E. Druid Hill Ave.

19 SEP 1 1948 (Date rec'd by registrar) (b) Burial Permit No. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 1050PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948, to 8/28 1948, and that I last saw her alive on 8/28 1948.

Immediate cause of death Cerebral vascular accident with Right + Left Heart failure — Duration

Due to Heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature St Elmo Brady M. D.
Address 1514 Division ST Date signed 8/30/48

St Elmo Brady.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G66418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 40 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant:
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof (month, day, year) Aug 29 1944
(c) Cemetery or crematory
Location

18 (a) Funeral director C. Harold Hill
(b) Address

19 (a) SEP 1 1944 (b) Huntington Woodlawn, Md.
Date rec'd by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Aug 1944, at 4 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Myocardial Degeneration

Other Conditions Fatty Degeneration of Liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D.
Medical Examiner.
Date signed 28 Aug 44

correct age is especially important. Regulations, please write the cause of death plainly and legibly.

666419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

666419 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Brentwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISLAM DAVIS Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): ? ? 1906

8. AGE: Years: 42 | Months | Days | If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Islam Davis Sr.
13. Birthplace: Va.

MOTHER
14. Maiden Name: ?
15. Birthplace: Va.

16 (a) Informant: Grace Davis
(b) Address: 1702 Brentwood

17 (a) Burial: Burial, cremation, or removal (b) Date thereof: 8/31/48
(month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: A. Halstead
(b) Address: 918 Druid Hill

19 SEP 1 1948 Filed
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 1948, at 9.20a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George A. Merrill M.D.
Medical Examiner.
Date signed 8-26-48

66420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G66420 14742
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 E Monument St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No),
If yes, name country

3 (a) FULL NAME Nannie O'Brien

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Freddie
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr) 1894

8. AGE: Years	Months	Days	If less than one day
54	?	?	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Banks
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosie
15 Birthplace Baltimore

16 (a) Informant Freddie O'Brien
(b) Address 1218 E Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Catholic
18 (a) Funeral director A. J. Lalelgud
(b) Address 918 E. Lanvale St

AUG 31 1948 (Date rec'd by registrar) (b) Huntington Hollins Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1948, to Aug 27 1948, and that I last saw her alive on Aug 27 1948.

Immediate cause of death	Duration
Lobar Pneumonia	10 days
Due to	
Due to	
Other Conditions Cirrosis of Liver	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ronald Bliz M. D.
Address 501 Cherry Hill Rd Date signed 8-27-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 166421

166421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 N Bulso ST
(c) Hospital or institution:
Provident Hospital 14-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N Bund St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Waters

3 (b) If veteran, name war unknown

3 (c) Social Security Account No. unknown

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1896

8. AGE: Years 48 | Months 9 | Days 4 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Mr John Waters
13. Birthplace unknown

MOTHER
14. Maiden Name Mrs Mary ?
15. Birthplace unknown

16 (a) Informant Deceased
(b) Address 521 N Bund ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halsted
(b) Address 918 Druid Hill Ave

DEC 1 1948
(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/48 1948, at 11.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1948 to 8/29 1948 and that I last saw h[illegible] alive on 8/29 1948

Immediate cause of death Cirrhosis of liver

Due to Excessive drinking of alcohol.

Due to

Other Conditions Pulmonary Congestion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature St Elmo Brady M.D.

Address 514 Dunbar ST Date signed 8/30/48

St Elmo Brady, M.D.

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Grant & Saratoga
(c) Hospital or institution: Mary Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city limits, write RURAL and give town)
(d) Street No. 5 [illegible] Buchanan Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Jackson

3 (b) If veteran, name war 0

3 (c) Social Security Account No. 216-05-1748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Business manager
11. Industry or business Continental Can Co.

FATHER
12. Name George Jackson
13. Birthplace

MOTHER
14. Maiden Name Ann C Weller
15. Birthplace Baltimore, Md

16 (a) Informant Mary Jackson
(b) Address 5313 5 31 6 Buchanan Pl Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Road 14

19 SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1948 to 8-31 1948 and that I last saw h/ alive on 8-31 1948

Immediate cause of death Acute pulmonary edema
Due to myocardial infarction
Due to Coronary Occlusion

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death) Mild

Date of operation
Major findings of operation:
of autopsy: Myocardial infarction

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence / at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bond Duvall, Jr. M. D.
Address Mary Hosp. Date signed 8-31-48

VS 150

X

JOHN F. QUINN

66423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

66423

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Falls Road (If rural, give location) W. 17
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-1627

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth F. Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 12-1890

8. AGE: Years 57 | Months 9 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Lowell, Mass. (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Miller Bros.

FATHER 12. Name Dethel Quinn
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Brady
15. Birthplace Mass.

16 (a) Informant Mrs. Ruth F. Quinn
(b) Address 4201 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Rd

19 SEP 1 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 21 1948 to Aug 30 1948 and that I last saw him alive on Aug 30 1948.

Immediate cause of death	Congestive failure	Duration
Due to	Arteriosclerosis Heart disease	1 week
Due to	CA pulmonary Cardiac pulmonary failure	
Other Conditions	Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John White M. D.

Address Univ. Hosp. Date signed 8-30-48

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

VS 150

666424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12-1a

666424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1333 Weldon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Weldon Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Newton Meyls

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura E. Meyls
6 (c) If alive, give age years

7. Birth date of deceased mo. day. yr January 22, 1873

8. AGE: Years 75 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Carroll Co., Maryland (Town, county, and state)
10. Usual Occupation Car Inspector
11. Industry or business Pa. Railroad

FATHER
12. Name Lewis O. Meyls
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Houck
15. Birthplace Maryland

16 (a) Informant Mrs. Laura E. Meyls
(b) Address 1333 Weldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 29, 1948 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1948 to Aug 29 1948 and that I last saw h alive on 27 Aug 1948

Immediate cause of death: Left Ventricular failure — Duration 1/2 hr.
Due to: Angina pectoris — Duration 1/2 hr.
Due to: Heart. — Duration 2 days

Other Conditions: Cerebral vascular renal disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel E. Fleischer, M.D.
Address 714 E. Preston Date signed 9-1-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

666425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. 666425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Morland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1626 Morland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Pearce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Michael J Bloom
13. Birthplace: Poland

MOTHER
14. Maiden Name: Katz
15. Birthplace: Poland

16 (a) Informant: Jew Pearce
(b) Address: 1608 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-1-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: E. Balt St

18 (a) Funeral director: Jack Levin Inc
(b) Address: 2100 Eutaw St

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-31-1948 at 6 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Aug 31 1948, and that I last saw h[illegible] alive on Aug 31 1948

Immediate cause of death: Acute Cardiac failure
Myocarditis
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury:

23. Signature: N B Freedle
Address: 2424 Druid Park Dr Date signed: 9/1/48

VS 150

6426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 Monument St
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

MOTHER / FATHER

12. Name Benjamin

13. Birthplace Russia

14. Maiden Name Ada

15. Birthplace Russia

16 (a) Informant Ada Adler

(b) Address 2003 Ruxton Ave

17 (a) Burial (b) Date thereof 9-1-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2400 Eutaw Place

19 (a) 9/1/48 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948 at 8:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/30 1948 to 8/31 1948 and that I last saw h alive on 8/31 1948.

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Diabetes Mellitus Bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Epstein M.D.
Address Sinai Hospital Date signed 8/31/48

VS 150

92

Please write clearly. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

166427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 166427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Mosher St
(c) Hospital or institution: —
14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50+ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fallins Gilmore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Cyrus Gilmore
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1855

8. AGE: Years 93 | Months ? | Days ? | If less than one day — hr. — min.

9. Birthplace Lancaster Co. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Silas Fallins
13. Birthplace Lancaster Co, Va

MOTHER
14. Maiden Name Mary —
15. Birthplace Lancaster Co. Va

16 (a) Informant Mrs Eleanor Lindsey
(b) Address 519 Mosher St 9-1-48

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City - Md

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Mund Hill Ave

19 SEP 1 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 August 1948, at 9 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 8-29-1948, and that I last saw h er alive on 8-29-1948.

Immediate cause of death
pulmonary edema — Duration 1 hour

Due to cardiac decompensation, acute — 2 hours

Due to arteriosclerotic cardiovascular disease — 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Cain, M. D.
Address 519 Mosher St Date signed 9-1-48

correct age is especially important. Physicians: please write the cause of death very plainly.

666428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

666428

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Bond

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Johnie Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	10	10	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Dennis Johnson
13. Birthplace Va

MOTHER 14. Maiden Name Matilda Lewis
15. Birthplace Va

16 (a) Informant Laura Jones
(b) Address 1215 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) Huntington, W. Va. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 29 1948, at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1948 to 8-29 1948 and that I last saw her alive on 8-29 1948

Immediate cause of death Cerebral Hemorrhage

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 612 Edmondson Ave Date signed

Please write plainly, with pen or pencil, and do not use ditto marks. Be sure to answer all questions; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666329

OF DEATH:
nore City, Maryland
address 2001 Penna. Ave
tal or institution:

h of stay in hospital or inst. (yrs., mos., or days) 14-3
h of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Penna. Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

L NAME Georgianna Denby

eteran, name war —

(c) Social Security Account No. —

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. W

me of husband or wife John Denby

6 (c) If alive, give age years

late of deceased (mo., day, yr.) 8-30-1948

Years	Months	Days	If less than one day
90			hr. min.

lace Baltimore Md. (Town, county, and state)

l Occupation Housewife

stry or business

ame Terry Moore

irthplace Md.

Maiden Name Unknown

irthplace Unknown

nformant Eugene Young

ddress 2001 Penna. Ave

Buried (b) Date thereof 9-2-48 (month) (day) (year)
urial, cremation, or removal

Cemetery or crematory Mt Auburn

Location Md.

Funeral director George S. Nelson

Address 703 Pennsylvania Ave

9 1948 (b) Washington Milliams, Md.
ate rec'd by Reg'l (for)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1948 at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26-1948 to 8-30-1948 and that I last saw h e alive on 8-30-1948

Immediate cause of death: Heat Exhaustion — Duration 3 days

Due to

Due to

Other conditions: Chronic Valvular Heart — 6 mos
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C. Boyce, M.D.
Address 816 N. Monroe St Date signed 9-1-48

191

66430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66450

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Cumberland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Wise

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife John E. Wise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	13	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louise Dip
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Beef
15. Birthplace Va

16 (a) Informant Annie Watt
(b) Address 627 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George F. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) — [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948, to Aug 28 1948, and that I last saw h[illegible] alive on Aug 27 1948

Immediate cause of death Arteriosclerotic Heart Disease — Duration ?

Due to

Due to

Other Conditions Enlarging Prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Carnes

Address 753 George St Date signed 8/29/48

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

8431 Dr. Post
6805 York Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G66431 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2632 Kirk Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Kirk Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Lee Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Jacob H. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 4. 1873

8. AGE: Years	Months	Days	If less than one day
75	-	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George C. Ness
13. Birthplace Md.

MOTHER
14. Maiden Name Hester A. Constantine
15 Birthplace Md.

16 (a) Informant Mrs. Blanche Ashcraft
(b) Address 2632 Kirk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date rec'd by Registrar 9-1-1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29th 1948, at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Aug 29 1948, and that I last saw her alive on Aug 21 1948.

Immediate cause of death Acute Cardiac Failure
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 605 York Rd. Date signed 8/31/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G. H. Merrill MD

G66432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66432
Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 S. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Chesaco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Zelenka

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James Zelenka
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1866

8. AGE: Years	Months	Days	If less than one day
82	1	8	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name John Sott
	13. Birthplace Bohemia
MOTHER	14. Maiden Name Elizabeth —
	15. Birthplace Bohemia

16. (a) Informant Cynthia Zelenka
(b) Address Essex Md

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18. (a) Funeral director Frank Bupack Sons
(b) Address 900 N. Chester St

19. (a) Date received by registrar SEP 1 1948 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Aug 30 1948 and that I last saw h[illegible] alive on Aug 30 1948.

Immediate cause of death BRONCHIAL PNEUMONIA — Duration 2 DAYS

Due to

Due to

Other Conditions DIABETES MELLITUS 20 YRS ??

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F Drenga M. D.
Address 209 S. Chester St Date signed 8/31/48

107

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66433 Harvey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66433

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 411 N. Madeira St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 411 N. Madeira St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Bednar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Barbara Bednar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 2, 1868

8. AGE: Years	Months	Days	If less than one day
80	1	26	hr. min.

9. Birthplace Laborer (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Bednar

13 Birthplace Bohemia

MOTHER 14. Maiden Name Not known

15 Birthplace Bohemia

16 (a) Informant Catharine Rospor

(b) Address 418 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balt Md

18 (a) Funeral director Frank Brockdorf

(b) Address 900 W. Chestnut

19 (a) (Date rec'd by registrar) (b) Registrar

SEP vs 1 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1948, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1948 to 8/31 1948 and that I last saw him alive on 8/30 1948.

Immediate cause of death Coronary Occlusion — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny

Address 2209 E Madison Date signed 8/31/48 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323
(c) Hospital or institution: South Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E OSTEND ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES STEPHAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-9671

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife ADELE STEPHAN

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) JULY 25-189[illegible]

8. AGE: Years 57 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation PRESSMAN

11. Industry or business U.S. LITHOGRAPHING Co

FATHER
12. Name HARRY F. STEPHAN
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name CATHERINE PEGLOW
15. Birthplace MARYLAND

16 (a) Informant ADELE STEPHAN
(b) Address 27 E OSTEND ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK ROAD

18 (a) Funeral director Bernard C Hank
(b) Address 121 E. West St
(c) 1 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948 at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948 to 8/31 1948, and that I last saw him alive on 8/31 1948.

	Duration
Immediate cause of death Ruptured cardiac aneurysm	?
Due to Myocardial infarction	5 days
Due to Coronary occlusion	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin
Address 1213 Light St. Date signed 9/1/48 M D

VS 150

G66435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G66435
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Cedardale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE ELIZABETH McCORMICK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles E. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1885

8. AGE: Years 63 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Utermohle
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret J. Leisher
15 Birthplace Md.

16 (a) Informant Mr. Charles E. McCormick
(b) Address 3402 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (c) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948, at 10:40 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948, to 8-31 1948, and that I last saw h alive on 8-31 1948.

Immediate cause of death: Respiratory Failure and Carcinoma — Duration:
Due to: Ca Head Pancreas.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Ca Head Pancreas - Metast. Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury
23. Signature Richard C. Hayden M. D.
Address Bon Secours Hosp. Date signed 8-31-48

VS 150

G66436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G66436

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1204 Bentalou St

(c) Hospital or institution: 16-

(d) Length of stay in hospital or inst. (yrs., mos., or days) one

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 N Bentalou St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Walter H. Melvin

3 (b) If veteran, name war: Spanish Amer

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 - 1879

8. AGE: Years	Months	Days	If less than one day
69	5	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Dancing Instructor

11. Industry or business

FATHER

12. Name John H. Melvin

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Isabella Talley

15. Birthplace Baltimore Md

16 (a) Informant Mrs Marie E Elliott

(b) Address 1204 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4-48 (month) (day) (year)

(c) Cemetery or crematory Bald. National

Location

18 (a) Funeral director Charles P Towell

(b) Address 2727 Edmondson Ave

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948, at 4:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from July 27 1948, to Sept 1 1948, and that I last saw h[illegible] alive on August 31 1948.

Immediate cause of death	Duration
Chronic Interstitial Nephritis	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chester Riland M. D.

Address 2532 Edmondson Ave Date signed 9-1-48.

PLEASE WRITE PLAINLY with indelible pencil. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1 sheet

G66437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1141

G66437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp. 21+
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Woodward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A Reynolds Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1906

8. AGE: Years 42 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry A. Reynolds
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ella M. Wegworth
15. Birthplace Baltimore Md

16 (a) Informant Mrs Ella M. Reynolds
(b) Address 813 Woodward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month, day, year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Govan & Son
(b) Address 901-03 Hollins St

19 (a) Date received (by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 3:30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cancer of lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature George F. Pickett M.D.
Medical Examiner.
Date signed 9-3-48

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 131

G666438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G666438

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Crenshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1882

8. AGE: Years 66 | Months 3 | Days | If less than one day: hr. ..... min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Austin Crenshaw
13. Birthplace Va

MOTHER 14. Maiden Name Sally Miller
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Sept 2/48 (month) (day) (year)

(c) Cemetery or crematory Crave Va
Location .....

18 (a) Funeral director McCaff G. Elliott Dingle
(b) Address 1129 N. Carlin St

19 (a) Date received by registrar (b) [illegible] for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Aug 31 1948, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 31 1948 and that I last saw h[illegible] alive on 8-21-1948

Immediate cause of death: Pulmonary Embolism, bilateral — Duration: 14 mos

Due to Sarcoma Uterus with Metastases to Lungs, Liver, Inguinal Lymph Nodes

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 8-20-48

Major findings of operation: Huge (30#) Tumor, Solid of Uterus

of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Kirwan Hanson, M.D.
M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-31-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G666439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G666439
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Dallas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BERTHA WORTHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 30 | Months | Days | If less than one day: hr. min.

9. Birthplace Warrington N.C.
(Town, county, and state)

10. Usual Occupation (House Wife)

11. Industry or business

FATHER
12. Name Mr. Alfred Kerney
13. Birthplace N.C.

MOTHER
14. Maiden name Mrs. Rosalee Kerney
15. Birthplace N.C.

16 (a) Informant Mr Harry Wortham
(b) Address 282 Dallas St.

17 (a) Burial, (cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Warrington N.C.
Location

18 (a) Funeral director Mrs. N. A. E. Pitts Daughter
(b) Address 1419 N. Caroline St.

19 (a) (Date received by registrar) Livingston Williams, Registrar
(b) Registered number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948, at 1:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-31-48 at 12:45 A.M.?
(b) Where did injury occur? 1418 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? Restaurant While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-31-48

VS 151

X

G66440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G66440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2469 Shirley Ave.
(c) Hospital or institution:
West Baltimore General Hospital DOA 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2469 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Ballasohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 4, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	27	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cleaners & Dyers

FATHER
12. Name Abraham Ballasohn
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Mrs. Abe Ballasohn
(b) Address 2576 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2/48 (month) (day)
(c) Cemetery or crematory North Point Rd. Cem.
Location German Hill Rd.

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 N. North Ave.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948, at 9:48a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck.
Fracture skull, crushing of Brain
Antem. cranial hemorrhage.
Due to External hemorrhage

Other Conditions Lacerations, bruises, bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was ~~suspected~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/31/48 at 9:35 A.M. 17-18
(b) Where did injury occur? Belvedere Ave. & Reistertown Rd.
Did injury occur at home, on farm, industrial place, in public place? pulic (While at work?) no
(d) Means of injury struck by streetcar, (ped.)

23. Signature Howard J. Mallecis M.D.
Medical Examiner.
Date signed 8/31/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital D O A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M

6 (b) Name of husband or wife Elenora Connor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 8, 1881

8. AGE: Years	Months	Days	If less than one day
67	5	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Alfred Hopkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Virginia Bentz
15. Birthplace Baltimore

16 (a) Informant Elenora Hopkins
(b) Address 9 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 1948 (Date received by registrar) (b) Fortington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 30 Aug 48

VS 151

G66442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G66442
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elton A. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude V. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1880

8. AGE: Years	Months	Days	If less than one day
67	9	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Carpenter (Retired)
11. Industry or business Carpenter

FATHER
12. Name John W. Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F. Jones
15 Birthplace Md.

16 (a) Informant Mrs. Maude V. Hall (Wife)
(b) Address 427 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 2 -48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) SEP 1948 (Date received by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Aug. 30 1948, and that I last saw h[illegible] alive on August 30 1948.

Immediate cause of death: Myelogenous Leukemia — Duration: 1 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W. LeGore M.D.
Address 601 S. Ellwood Ave Date signed 9/3/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G66443

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Port Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Drsata

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida Ludwig Drsata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	15	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired tailor
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Mrs. Ida Ludwig Drsata - wife
(b) Address 802 N. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) SEP 1 1948 (Date received) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1948 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27- 1948 to 8-30 1948. and that I last saw h[illegible] alive on 8-30- 1948.

Immediate cause of death	Duration
Pneumonia	1 Day
Due to	over
Due to	
Other Conditions Parkinson's disease	20 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. F. Drsata Jr. M. D.
Address 2408 W. Lafayette Ave Date signed 8-31-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 199

G66444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G66444
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Kostek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ John Kostek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1881

8. AGE: Years	Months	Days	If less than one day
67	5	11	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Sako
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Theresa Ballay
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Helen Picek - daughter
(b) Address 2420 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) 1948 (b) [illegible] for Baltimore, Md.
(Date received by Registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948 at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 8/30 1948, and that I last saw h alive on 8/29 1948.

Immediate cause of death
heart exhaustion — Duration 4 days.
Due to
Due to
Other Conditions
acute myocardial infarction
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L C Schimunek M. D.
Address 447 N. Kenwood Ave. Date signed 9/2/48

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G66445

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 47c

G66445
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 O Donnell st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 O Donnell st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Kuchta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1906

8. AGE: Years 42 | Months 1 | Days 21 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Ships Builder

11. Industry or business Md. Dry Dock

FATHER
12. Name John Kuchta
13. Birthplace Poland

MOTHER
14. Maiden Name Agusta Ketcel
15. Birthplace Poland

16 (a) Informant Miss Eva Kuchta
(b) Address 2825 O Donnell st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Stanislaus Cem.
Location Dundalk Ave

18 (a) Funeral director Marie E. Stalkowski
(b) Address 1000 N. Kenwood Ave

19 (a) (Signature of registrar) Registrar
(Date received)

SEP 1
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1948 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 July 1948 to 31 Aug. 1948, and that I last saw him alive on 31 Aug. 1948

Immediate cause of death: Respiratory failure — Duration: 1 hr.

Due to: Carcinomatosis, Pleural effusion — 3 mos.

Due to: Bronchogenic, carcinoma of lung. — 6 mos.

Other Conditions: Cachexia, Anaemia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town), (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd M. D.

Address 2601 Eastern Ave Date signed 1 Sept. 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate should be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G66446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66446
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Keating ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss Mary Lindsay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/10/1882

8. AGE: Years	Months	Days	If less than one day
66	6	20	— hr. — min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Mr. John Lindsey
13. Birthplace West Virginia

MOTHER
14. Maiden Name Augusta Dering
15 Birthplace West Virginia

16 (a) Informant Patients Adm. Record
(b) Address —

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept. 2/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Blvd.

18 (a) Funeral director Easton Sons
(b) Address 608 Fredericks Ave Catons

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

EP

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1948 to Aug 30 1948, and that I last saw her alive on aug 30 1948.

Immediate cause of death Cerebral vascular accident — Duration 16 days
Due to —
Due to —
Other Conditions hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

Signature W. T. Carr M.D.
Address Union Memorial Hosp. Date signed 8-30-48

X

G66447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66447 / 83a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Annie L. Thomas

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Robert A.
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 15, 1873
8. AGE: Years 75 | Months 4 | Days 15 | If less than one day ..... hr. ..... min.
9. Birthplace Royal Oak, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Roberts
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Smith
15. Birthplace Royal Oak Md

16 (a) Informant Mrs. Esther Scott
(b) Address 325 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2 1948 (month) (day) (year)
(c) Cemetery or crematory Talbot Co. Md
Location Spring Hill

18 (a) Funeral director Mrs. Geo. R. Holland
(b) Address 1631 Druid Hill Ave

19 SEP 1 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948, at 1130 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 30 1948 and that I last saw her alive on Aug 29 1948.

Immediate cause of death: Cerebral hemorrhage
Due to: Arterial hypertension
Due to: .....
Other Conditions: .....
(Include pregnancy within 3 months of death)

Duration: 3 wks / unk

Date of operation: None
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature George W. Donald M.D.
Address 644 N. Carey Date signed 9/1/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66448

JL - 122578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66448

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mt. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad F. Schulz

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-4186

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma Schulz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 1, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	30	hr. min.

9. Birthplace Md. (Balto.)
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 SEP 2 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1948, at 11.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1948 to Aug. 31 1948, and that I last saw h in alive on Aug. 31 1948.

Immediate cause of death	Duration
Sub-arachnoid hemorrhage.	
Due to Hypertensive Cardiovascular Disease.	
Due to	
Other Conditions Generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Abdomen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balt City Hosp Date signed Sep 48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

VS 153

G66449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66449

Registered No.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5305 Wright Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Virginia B. Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Adolph E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1863

8. AGE: Years	Months	Days	If less than one day
84	9	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Martin Rudolph
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Woods
15 Birthplace Balto. Md.

16 (a) Informant William Rudolph
(b) Address 1253 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Mortician for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 1:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 28 1948 to Sept 1 1948 and that I last saw h[illegible] alive on Sept 1 1948

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence a: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray C. Parsons, Jr. M. D.
Address St. Joseph's Hospital Date signed 9/1/48

VS 150

666150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1001 St Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archibald H. Dewdney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 49th years

7. Birth date of deceased (mo., day, yr.) July 6th 1898

8. AGE: Years: 50 | Months: 1 | Days: 12 21 | If less than one day: hr. min.

9. Birthplace: Switzerland (Town, county, and state)

10. Usual Occupation: Vice Pres.

11. Industry or business: (Self) Shoreman (Co) Inc.

FATHER 12. Name: Harry Lovell Dewdney

13. Birthplace: England

MOTHER 14. Maiden Name: Fanny (Deceased)

15. Birthplace: Switzerland Deceased

16 (a) Informant: Martha Dewdney

(b) Address: 95 Lexington Ave. N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn

Location: N.Y. City N.Y.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St.

19 (a) SEP 2 - 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1943. to Aug 31. 1948. and that I last saw h[illegible] alive on Aug. 31 1948.

Immediate cause of death Pulmonary edema — Duration: 2 or 3 minutes

Due to: Coronary occlusion — Duration: 2 or 3 hours

Due to: Arterio sclerosis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard. M. D.

Address 12 E. Eager St. Date signed Sept. 1, 48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

066451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 066451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Lyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Lyndhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes McKay Barbour

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~ Alexander K. Barbour
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1875

8. AGE: Years 72 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name McKay
13. Birthplace Scotland

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Jean Chase
(b) Address 32 Village Green, New Milford, Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Sept 2 1948 (Date received by Registrar) (b) Huntington W. Va.

SEP 2 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1948 at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1943 to Aug. 31 1948, and that I last saw h e alive on Aug. 31 1948.

Immediate cause of death: (a) Cerebral Hemorrhage
Due to: Hypertensive Cardio Vascular Disease
Due to:
Other Conditions: Cerebral Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Duration: (a) 2 days. (b) 10 yrs. (c) ?

Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 410 E. Liberty St. Date signed 9/1/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

666452

Registered No.

BC - 48-18826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street.

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 Ridgely St. (If rural, give location)

(e) Citizen of foreign country? x (Yes or No)

If yes, name country .....

3 (a) FULL NAME Infant Boy of Willard & Charlotte Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1948

8. AGE: Years | Months | Days | If less than one day 8 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Willard Richardson

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Charlotte Chrzanowski

MOTHER 15. Birthplace Pennsylvania

16 (a) Informant Hospital Record

(b) Address South Baltimore General Hosp.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 2 48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cem.

Location Glen Burnie Md.

18 (a) Funeral director Bernard C Hale

(b) Address .....

19 SEP 2 - 1948 (Date rec'd by Registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept 1 1948 and that I last saw him alive on Sept 1 1948.

Duration 8 hrs

Immediate cause of death: Atelectasis

Due to Prematurity

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation ..... Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Charles R Woodward M.D.

Address 1213 Light St Date signed 9-1-48

VS 150

666453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666353

BL-48-18827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Ridgely St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Infant Boy of Willard & Charlotte Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31 1948

8. AGE: Years | Months | Days | If less than 1 day: 8 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willard Richardson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Charlotte Szczepanski
15. Birthplace Pennsylvania

16 (a) Informant Hospital Record
(b) Address South Baltimore Gen. Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glen Burnie Md

18 (a) Funeral director Bernard C. Harlan
(b) Address 121 E. West St.

19 SEP 2 - 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept. 1 1948, and that I last saw him alive on Sept. 1, 1948.

Immediate cause of death: Atelectasis — Duration: 8 hrs.

Due to: Prematurity — Duration: 15 min.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M.D.
Address 1213 Light St. Date signed 9-1-48

VS 150

66454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 2002

Registered No. 666454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Bolton St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Bolton St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN C. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1891

8. AGE: Years (56) Months 8 Days 30 If less than one day hr. min.

9. Birthplace Joplin, Mo. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Elijah J. Williams
13. Birthplace ?

MOTHER 14. Maiden Name Alice Virginia Campbell
15. Birthplace ?

16 (a) Informant George J. Tinsley
(b) Address Equitable Trust Co.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month, day, year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1905 Eutaw Place

19 SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Impossible to state

Due to Advanced postmortem changes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 8-28-48

OVER

VS 151

I MEANS WHITE, NEGRO, MULATTO, INDIAN, ETC. ETC. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 664455

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Saratoga Sts
(c) Hospital or institution: Hutzler Bros. Dept. Store
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4113 Chatham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Schapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 10, 1907

8. AGE: Years	Months	Days	If less than one day
41	5	22	hr. min.

9. Birthplace Conn (Town, county, state)

10. Usual Occupation

11. Industry or business Registered Nurse

FATHER
12. Name Aaron Selig Baker
13. Birthplace Russia

MOTHER
14. Maiden Name Elizabeth Leibman
15. Birthplace Russia

16 (a) Informant Louis Schapiro
(b) Address 4113 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Princess Ann Cemetery
Location Norfolk Va

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1108-1126 W North Ave

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Washington Williams, Mo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1948 at 4 1/2 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner.
Date signed 9-1-48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC-48-16396

G66456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G66456

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Lutherville

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Clark Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/48

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robb Tyler

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Worthington

15 Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP 2 - 1948 (Date rec'd by Registrar) (b) Huntington Hilligoss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 12 NP M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1948 to 8/29 1948 and that I last saw him alive on 8/29 1948.

Immediate cause of death PREMATURITY

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)

(e) Means of injury

23. Signature Alan C Thomas M. D.

Address JOHNS HOPKINS HOSPITAL Date signed

VS 159

66457 B-48-2559 94 ✓ 66457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Bond St (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Boy Kazzynski

3 (b) If veteran, name war / | 3 (c) Social Security Account No. ///

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 8/28/48

8. AGE: Years	Months	Days	If less than one day
		1	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Marion Kazzynski
13. Birthplace Md

MOTHER
14. Maiden Name Nanda Goscinski
15. Birthplace .....

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) SEP 2 1948 (State record by registrar) (b) Huntington Williams, registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1948, to 8/29 1948, and that I last saw h in alive on 8/29 1948.

Immediate cause of death PREMATURITY

Duration .....

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Alan C Hermann M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

666458 BC-gs-128-26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Williman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jones (1,6454)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/48

8. AGE: Years	Months	Days	If less than one day hr.	min.
0	0	5		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name George Fitzgerald
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Doris Jones
15. Birthplace Baltimore, Maryland

16 (a) Informant Hospital Records
(b) Address The Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 4:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1948, to August 27 1948, and that I last saw her alive on August 27 1948.

Immediate cause of death	Duration
Kernicterus	
Due to Hyaline membrane disease Atelectasis neonatorum	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy Kernicterus enlarged liver & spleen

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D Bruns M. D.
Address The Johns Hopkins Hospital Date signed 8-27-48

VS 150

161c

66459 N.H. 4 W
66459 BC = 48-02719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

Registered No. 66459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 / 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-3-48

8. AGE: Years | Months: 7 | Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joe Brown
13. Birthplace N.C.

MOTHER 14. Maiden Name Carrie Rambert
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Baltimore, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Pennsylvania Ave

19 (a) SEP 2- 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1948, at 6:39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-1948 to 8-31-1948, and that I last saw h alive on 8-31-1948.

Immediate cause of death: Cerebral Anoxia — Duration

Due to: Status Epilepticus

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Markowitz M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

666460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, if obtainable. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Hollendia (Allender)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Will Allender
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Barfield Allender
(b) Address 1714 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-48 (month) (day)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bloomsbury ave

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Chronic Alcoholism
Laceration at head
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/28/48 at about 5:00 P.M.
(b) Where did injury occur? Mercy Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Jumped from 5th floor window

23. Signature [illegible] M.D. Medical Examiner.
Date signed 8/30/48

VS 151

G66461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66461 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 ST. MARGARET ST.
(c) Hospital or institution: BROOKLYN, MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 ST MARGARET ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** GEORGE FILIPIAK

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. WIDOWED
6 (b) Name of husband or wife ANNA (NEINTZ)
6 (c) If alive, give age D years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 73 | Months | Days | If less than one day hr. min.
9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation MINER
11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace AUSTRIA

16 (a) Informant MR PETER FILIPIAK
(b) Address 3606 ST MARGARET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory TRANSFIGURATION CEM
Location SHAMOKIN, PA.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST. -30

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 1, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1948 to Sept 1 1948 and that I last saw him alive on Aug 31 1948.

Immediate cause of death coronary occlusion — Duration
Due to hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip H. Kuetter M. D.
Address 302 Patapsco Ave Date signed 9/2/48

×

666462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 666462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 445 Little Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY CALLAHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 6 1913

8. AGE: Years 35 | Months — | Days 23 | If less than one day hr. min.

9. Birthplace: S. C. (town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Grant Callahan
13. Birthplace: S. C.

MOTHER
14. Maiden Name: Mattie Talbott
15. Birthplace: S. C.

16 (a) Informant: Minnie Callahan
(b) Address: 446 W Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary.
Location: A Halstead

18 (a) Funeral director: Allied Hall
(b) Address: 916 Pennsylvania Ave.

19 (Date rec'd by registrar) SEP 2- 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 10 a.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wounds of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 29 1948 9:30 a.M.
(b) Where did injury occur? Druid Hill Ave. & Pace St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury: Firearms

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 8/30/48

VS 151

X

666463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Register No. 666463

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 Wilkens Avenue
(c) Hospital or institution:
2015
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Wilkens Avenue
(Also give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME PETER PAHOULIS

3 (b) If veteran, name war **
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894 ?

8. AGE: Years 54 ? | Months | Days | If less than one day: hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Restaurateur

11. Industry or business

FATHER
12. Name John Pahoulis
13. Birthplace Greece

MOTHER
14. Maiden Name Unknown
15. Birthplace Greece

16 (a) Informant George S. Agnew
(b) Address 39 Murdock road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Geo. S. Agnew Fun. Homes
(b) Address 48 E. Mt. Royal Ave.

19 (a) SEP 2 1948 (Date rec'd by registrar) (b) Huntington Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anemia

Due to Gastric ulcer

Other Conditions Malnutrition
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Where? work?)
(d) Means of injury
(e) Signature Earl L. Royer M.D.
Medical Examiner
Date signed 31 Aug 48

X

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666464 JL - 122072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1548

Registered No. 666464

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Rupp

3 (b) If veteran, name war [redacted]
3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John Rupp
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. April 30, 1861

8. AGE: Years	Months	Days	If less than one day
87	4	1	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Baker
13. Birthplace England

MOTHER
14. Maiden Name Charlotte Percy
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1948, at 1.25 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Sept. 1 1948, and that I last saw her alive on Sept. 1 1948.

Immediate cause of death Bronchopneumonia — Duration days

Due to Acute Dilatation — hrs

Due to

Other Conditions ASCVD

(Include pregnancy within 3 months of death)

Date of operation 8/23/48

Major findings of operation: Carcinoma of the rectum, Ca

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] M. D.
Address [redacted] Date signed [redacted]

VS 150

Especially important. Physicians: please write the causes of death clearly and legibly.

666465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 ✓

Registered No. 666465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapelgate Lane
(c) Hospital or institution: Pine Crest Sanatarium 4-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balti.
(c) City or town (If outside city or town limits write RURAL and name town)
(d) Street No. 1000 E Preston St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Katherine Hennick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Feb. 20, 1867
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/[illegible]

8. AGE: Years	Months	Days	If less than one day hr.	min.
81	6	11		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Antone Ruppenger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Zieglar
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Cole
(b) Address 1000 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 908 East Biddle St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1948 to August 31 1948 and that I last saw her alive on August 31 1948

Immediate cause of death Chronic Myocarditis & Myocardial Degeneration — Duration ?

Due to Senility

Due to

Other Conditions Hypostatic pneumonia — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the one to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2230 W Fayette St Date signed 9/1/48

666466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital 2nd Mayo

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 210 Upnor Road (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Regina L. Hisley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph M.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr) 2/27/90

8. AGE: Years	Months	Days	If less than one day hr.	min.
58	6	4		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER	12. Name	James A. Logue
	13. Birthplace	Balto
MOTHER	14. Maiden Name	Harriet Lucas
	15. Birthplace	Balto.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Windfield

(b) Address 900 Earl Biddle St.

19 (a) SEP 2 - 1948 (Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1948 to Aug 31 1948 and that I last saw h[illegible] alive on Aug 31 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ray E. Pearson Jr. M.D.

Address St. Joseph's Hospital Date signed 8/31/48

VS 150

To be approved by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. G66467

G66467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1402 N. Carolina St.,

(c) Hospital or institution: St. Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. Sudd.

(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4514 Frankford Ave, Balto. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME George Ignatius Groeninger

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-05-1753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Margaret Mary

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31, 1888

8. AGE: Years	Months	Days	If less than one day
60	0	30	hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Packer - Burroughs Bros.

11. Industry or business:

FATHER — 12. Name ✓

FATHER — 13. Birthplace ✓

MOTHER — 14. Maiden Name ✓

MOTHER — 15. Birthplace ✓

16 (a) Informant: Margaret Mary Groeninger

(b) Address: 4514 Frankford Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-3-48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Balto

18 (a) Funeral director: L. J. Ruck

(b) Address: 5305 Harford Rd.

19 (a) Date received by registrar: 9-2-1948 (b) Huntington Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 48 at 9:20 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Aug 30 19 48 to Aug 30 19 48, and that I last saw him alive on Aug 30 19 48.

Immediate cause of death: Hyperpyrexia — Duration

Due to: Hyperpyrexia from Heat Stroke

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature: John M. Rehfuss M. D.

Address: St. Joseph Hospital Date signed: Aug 30, 1948

For D. H. Davis Co. Howard J. Mackey M.D.

G666468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G666468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1100 N. Caroline Street

(c) Hospital or institution: St. Joseph's Hospital 26-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 5103 Anthony Avenue (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. James Bernard Kerby

3 (b) If veteran, name war None

3 (c) Social Security Account No. 205-07-6542

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Frances Morwood

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) April 21, 1896

8. AGE: Years 52 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Renova, Pennsylvania (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B & O Railroad

FATHER

12. Name Frederick Kerby

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Sarah Mulvihill

15 Birthplace Pensylvania

16 (a) Informant Mrs. Catherine F. Kerby -Wife

(b) Address 5103 Anthony Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9-4-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road, Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

SEP 2 - 1948 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 19 to 8-31- 19 48, and that I last saw him alive on 8-31-48 19

Immediate cause of death Coronary Occlusion — **Duration**

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Ray E. Pearson Jr. M.D.

Address St. Joseph's Hosp. Date signed 8/31/48

VS 150

G66463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

G66369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac D. Bloom

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma F. Mitchell

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 27th., 1883

8. AGE: Years: 65 | Months: 6 | Days: 4 | If less than one day: ##### hr. min.

9. Birthplace: New York State (Town, county, and state)

10. Usual Occupation: Billiard Room Proprietor

11. Industry or business:

FATHER
12. Name: Ross Bloom
13. Birthplace: New York State

MOTHER
14. Maiden Name: Elizabeth Levis
15. Birthplace: New York State

16 (a) Informant: Mrs. Emma F. Bloom - Wife
(b) Address: 2014 Kennedy Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/3/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: E. North Avenue Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1785 Harford Avenue

19 (a) 1948 (Date received by registrar) Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948, at 11:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic C.V disease

Due to

Other Conditions: Bronchiectasis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: D. P. Fabian M.D. Medical Examiner.
Date signed 9/1/48

EP

VS 151

G66470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 Worsley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Worsley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23-1901

8. AGE: Years	Months	Days	If less than one day
46 47	11	8	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Green
13. Birthplace Va

MOTHER
14. Maiden Name Mattie
15. Birthplace Va

16 (a) Informant Arthur Green
(b) Address 408 Worsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48
(c) Cemetery or crematory U.S. Veterans National
Location Baltimore

18 (a) Funeral director Raynes Sandore
(b) Address 1412 E. Preston St

SEP 2 1948 (b) Huntington Williams, M.D. Registrar
(a) Date received by registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. H. Merrill M.D. Medical Examiner.
Date signed 9-1-48

X

BC-C30576

G66471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 14

Registered No. G66471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA
(c) Hospital or institution: MERCY HOSP. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo. 8d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 MARY Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID RHEA (DAVID EDGAR RHEA)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 22, 1945

8. AGE: Years 3 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name EDGAR RHEA.
FATHER 13. Birthplace WASHINGTON D.C.

MOTHER 14. Maiden Name CHARLOTTE MILLER
MOTHER 15 Birthplace BALTIMORE, Md

16 (a) Informant Mr. Edgar S. Rhea
(b) Address 3204 Mary Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/3/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 2 - 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1948 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1948. to Sept 1 1948. and that I last saw him alive on Aug 31 1948.

Immediate cause of death: Resp failure — Duration

Due to Tuberculous Meningitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy Tuberculous meningitis & internal
of autopsy: by Dr. Coughlan

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Frank L. Avonta, M.D.
Address Mercy Hosp. Date signed 9/1/48

VS 150

G66472 ✓ G66472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-5
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Clintree dt (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK (KOUKAL) Koukol

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie Koukol (Koukal)
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept. 12. 1876

8. AGE: Years 71 | Months 9 | Days 19 | If less than one day / hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Pipe maker

11. Industry or business

FATHER 12. Name Frank Koukal Koukol
FATHER 13. Birthplace Bohemia

MOTHER 14. Maiden Name Centonec
MOTHER 15. Birthplace Bohemia

16 (a) Informant Marie Koukol
(b) Address 1509 Clintree dt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel County

18 (a) Funeral director Frank Coppersmith
(b) Address 1200 W. Baltimore St

19 (a) 8-2-48 (Date filed by Registrar) Wellington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948, at 8-40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/23 1948, to 9/1 1948, and that I last saw him alive on 9/1 1948.

Immediate cause of death: Hemopneumothorax, bilat. — Duration: 1 day
Pulmonary embolism, rt. — 2 hrs.
Due to Carcinoma of esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8/31/48
Major findings of operation: Carcinoma of esophagus
of autopsy as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin
Address 1213 Light St. Date signed 9/1/48

VS 150

G66473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66473 Registered No.

48C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens ave

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 111 Smith wood ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Sue H. Larkin

3 (b) If veteran, name war: Wld War I

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Allan J.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): June 17, 1894

8. AGE: Years: 54 Months: 2 Days: 19 If less than one day: hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: House wife.

11. Industry or business:

FATHER

12. Name: Peter Scheidel

13. Birthplace: Pa. (dec'd

MOTHER

14. Maiden Name: Caroline Ruff.

15. Birthplace: Germany (dec'd

16 (a) Informant: Husband

(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)

(c) Cemetery or crematory: National Cem.

Location: Baltimore

18 (a) Funeral director: George A. Hartley

(b) Address: Fulton ave & Fayette St.

19 (a) Sep 2 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/1948, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1948 to 8/31 1948 and that I last saw h- alive on 8/31 1948.

Immediate cause of death: GENERALIZED CARCINOMATOSIS

Duration:

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Peter B. Steer M.D.

Address 1 E. Lexington St. Date signed 9/2/48

G66474 ✓ G66474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: CHILDREN'S HOSPITAL SCHOOL
(a) Baltimore City, Maryland
(b) Street address GREENSPRING AVE. NEAR KEYWORTH
(c) Hospital or institution: CHILDREN'S HOSPITAL SCHOOL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 POPLAR GROVE ST. (16) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN JAMES POWERS

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: DOROTHY VIRGINIA SCHISTER POWERS
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-14-'24
8. AGE: Years 23 | Months 11 | Days 18 | If less than one day hr. min. 17
9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE RECENTLY
11. Industry or business —

FATHER
12. Name SUMNER POWERS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANNA APPLER
15. Birthplace BALTIMORE, MD.

16 (a) Informant WIFE
(b) Address 2102 POPLAR GROVE ST. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave. Baltimore, Md.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 1 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1948, to 9-1 1948, and that I last saw him alive on 9-1 1948.

	Duration
Immediate cause of death: CARDIAC FAILURE	15 MIN
Due to: VIRUS BRONICHITIS	1 WK.
Due to: POST-POLIOMYELITIC RESPIRATORY & GENERALIZED PARALYSIS	1 YEAR
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature O. Donald Chrisman M. D.
Address Children's Hospital School Date signed 9-1-48

VS 3

1 X

G66475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 ✓

Registered No. G66475

-PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens ave.
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Wolfblock ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillie M. LeHr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband ~~or wife~~ JOHN LEHR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 1869

8. AGE: Years 79 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jacob Hoffman dec'd

13. Birthplace Md.

MOTHER 14. Maiden Name Barnard.

15. Birthplace ?

16 (a) Informant Daughter.

(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) SEP - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948 at 1.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-31 1948 and that I last saw h[illegible] alive on 8-31 1948.

Immediate cause of death Acute Renal Failure.

Due to Intestinal Obstruction.

Due to Cachexia.

Other Conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Outlaw T. Hare Jr. M.D.

Address St. Agnes. Hosp. Date signed 8/31/48

VS 150

1221R

G66476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G66476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life-ind.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 NORTH CHARLES ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MABEL E. LEIGH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife THOMAS B. LEIGH
6 (c) If alive, give age • years

7. Birth date of deceased (mo., day, yr.) 4-12-1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	4	19		

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE,
11. Industry or business

FATHER
12. Name MR. CHARLES ALBERT THOMAS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name REBECCA ELLEN SOPER
15 Birthplace MARYLAND

16 (a) Informant THOMAS B. LEIGH
(b) Address 4216 NORTH CHARLES ST, BALT. MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 2 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1948 at 9 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 9-1 1948 and that I last saw her alive on 9-1 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4da.
Due to Hemorrhagic Purpura unknown Etiology	2 wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature H. R. Freeman, M.D.
Address 11 W. 29th ST Date signed Sept 1, 1948

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

✓ G66477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert 27

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5308 Tremore Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Carroll Clark

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: nee Caple Floss Clark

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1889 2-3-89

8. AGE: Years 59 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance Broker

11. Industry or business Secretary & Treasurer Warfield & Dorsey Co.

FATHER 12. Name Agustus B. Clark

FATHER 13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Elizabeth S. Brown

MOTHER 15. Birthplace Baltimore, Md.

16 (a) Informant Roland A. Clark (son)

16 (b) Address 4407 Arabia Ave. Baltimore

17 (a) Burial (Burial, cremation, or removal)

17 (b) Date thereof 9/4/48 (month) (day) (year)

17 (c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

18 (b) Address Balto., Md.

19 FEB 2 - 1948 Huntington Williams, M.D. Registrar

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1948 at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 August 1948 to 2 Sept 1948 and that I last saw him alive on 1 Sept 1948

	Duration
Immediate cause of death: Pulmonary embolism	
Due to: Post-op amputation Rt Leg Thrombo-angiitis, obliterans	
Due to:	
Other Conditions: Arteriosclerotic heart disease Rheumatoid Arthritis (Include pregnancy within 3 months of death)	

Date of operation 8-24-48

Major findings of operation: Supra condylar amputation rt leg.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature W. Alpin Arnold M. D.

Address Union Mem. Hospital Date signed 9-2-48

99

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 666478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Larchmont (If outside city or town limits, write RURAL and give town)
(d) Street No. 5903 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ida S. Robinson

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Inglis Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Aug. 5, 1870

8. AGE: Years 78 | Months 0 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William H. Rynehart
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Sarah Dillon
15. Birthplace: Martinsburg, W. Va.

16 (a) Informant: Mrs. S. Elizabeth Smith
(b) Address: Old Court Rd., Woodstock, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 2 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/48 19 , at 2 1/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/48 19 , to 9/2/48 19 , and that I last saw her alive on 9/2/48 19 .

Immediate cause of death: Cardiac failure — **Duration**

Due to: Hypertension Arteriosclerosis

Due to:

Other Conditions: Carcinoma of Bladder with secondary tumors
(Include pregnancy within 3 months of death)

Date of operation: 9

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at , M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Frank E Brynbock M. D.
Address University Hospital Date signed 9/2/48

VS 15a

1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 97 ✓ 166479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA N. GARNAND

3 (b) If veteran, name war: none
3 (c) Social Security Account No: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William T. Garnand
6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1870

8. AGE: Years 78 Months 6 Days 11 If less than one day hr. min.

9. Birthplace: New York City (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Frederick Gebhardt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. L. Stein
(b) Address: 3610 Hineline Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 2 - 1948 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Address 438 Cathedral St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1948, at 8:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 30 1948, to Sept 1 1948, and that I last saw h[illegible] alive on Sept 1 1948.

Immediate cause of death: Hypostatic Pneumonia — Duration: 2 days
Due to: Chronic General Arteriosclerosis — Duration: several years
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Keown M.D.
Address 438 Cathedral St.
Date signed 9/1/48

VS 153

PORSINGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 50

666460

Registered No. 666460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 524 S Streeper
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Streeper St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian A Porsinger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick Porsinger

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70				

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name James Boyer
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Burnitt
15. Birthplace Balto

16 (a) Informant Mrs Ruth Lasinoski
(b) Address 524 S Streeper

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3- (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Allegany Ave Huntington Station, Md

19 SEP 2 - 1948 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 31 1948, and that I last saw her alive on Aug 31 1948

Immediate cause of death Carcinoma of Breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Eugene Zeller, M.D.

Address 2739 Eastern Ave Date signed 8/31/48

G66481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-2

Registered No. G66481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1520 STONEWOOD RD

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 27 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1520 Stonewood Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CLARA M. RINEHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 18, 1863

8. AGE: Years	Months	Days	If less than one day
85	7	13	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name LOUIS RINEHART

13. Birthplace MARYLAND

MOTHER 14. Maiden Name ANNIE PENN

15. Birthplace MARYLAND

16 (a) Informant MRS GEORGE SHILLRAT

(b) Address 1620 STONEWOOD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 3 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Henry H Wittyke

(b) Address 4601 Edmondson Ave Catonsville Md

19 SEP 2- 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 31 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug. 31 1948, and that I last saw her alive on Aug 31 1948.

Immediate cause of death Cardiac failure — Duration 3 wks.

Due to Arteriosclerotic and hypertensive heart disease — Duration ?

Due to Coronary Sclerosis

Other Conditions Senility, Cellulitis of face

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bernard Burgin M.D.

Address 6721 Reisterstown Rd Date signed Sept. 1

VS 150

66482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

✓ 66382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1731 Park Avenue

(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 10

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1731 Park Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME THELMA GROTH BENDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife J. Luther Bendt

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr) July 23, 1909

8. AGE: Years	Months	Days	If less than one day
39	1	8	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER 12. Name HANS H. GROTH

FATHER 13. Birthplace DENMARK

MOTHER 14. Maiden Name MATHILDA M

MOTHER 15. Birthplace U.S.A.

16 (a) Informant ~~Self~~ J. Luther Bendt

(b) Address 1731 Park Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 4 1948 (month) (day) (year)

(c) Cemetery or crematory MORELAND MEMORIAL

Location TAYLOR AVE

18 (a) Funeral director Harry H. Withe

(b) Address 4101 Edmondson Ave

19 SEP 2 1948 (b) Huntington Pallisades, Md. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 1 1948, and that I last saw her alive on August 1948.

Immediate cause of death ~~Heart Attack~~ Medullary Failure — Duration

Due to Increased Intracranial Pressure

Due to Central Nervous System Torulosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William F. Tillery M.D.

Address 13 W. Madison St. Date signed 9/1/48

VS 150

G66483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

✓ G66483 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly:

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Edmondson Ave #29 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Burke Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7788

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/12/91

8. AGE: Years 57 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business THOMAS HICKS + SONS

FATHER
12. Name CHARLES E BURKE
13. Birthplace MD.

MOTHER
14. Maiden Name ANNE HINES
15. Birthplace MD

16 (a) Informant MRS ROBERT BURKE
(b) Address 3524 EDMONDSON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 3, 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wyse
(b) Address 4101 Edmondson Ave

19 (a) SEP 1 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 48 to 8/31 19 48 and that I last saw h alive on 8/31 19 48

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to Arteriosclerosis	
Other Conditions Prostatectomy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Coronary Thrombosis Prostatectomy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C J Black
Address Maryland General Date signed 8/31/48

94a

C66484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C66484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 N. Chapelgate Lane

(c) Hospital or institution: Pernest Sanatarium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Hampstead (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of (foreign country)? No Yes or No

If yes, name country

3 (a) FULL NAME Leander E Albaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Alice Albaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27-1861

8. AGE: Years 87 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired painter

11. Industry or business

FATHER 12. Name Julius Albaugh

13. Birthplace Md

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs Howard Albaugh

(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5/48 (month) (day) (year)

(c) Cemetery or crematory Hampstead

Location Carroll Co Md

18 (a) Funeral director Edw Clifton

(b) Address Hampstead Md

19 SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Mgr Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to September 1 1948, and that I last saw h/m alive on Sept. 1 1948

Immediate cause of death	Duration
Senility with senile dementia	2 yrs
Due to Arteriosclerosis	
Due to	
Other Conditions Enlarged heart	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (type of place)

(e) Means of injury

23. Signature Melvin M. Bowlan M. D.

Address 233 N Fayette St Baltimore Md Date signed 9-1-48

97

666385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3039 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 48 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Shannon Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Dayton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Vic Dayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	1	26		

9. Birthplace Western Maryland (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Charles Dayton
13. Birthplace ?

MOTHER
14. Maiden Name Thomasine Muia
15. Birthplace ?

16 (a) Informant Mrs. Dale
(b) Address 3039 Shannon Drive

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 3. 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Western Cem., Md.

18 (a) Funeral director John A. Morgan
(b) Address 3006 E. Baltimore St

19 (a) Date received SEP 2 1948 (b) (Registrar) Washington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1948 at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V. disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Schumb M.D.
Medical Examiner.
Date signed 9/2/48

G66486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G66486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania County
(c) City or town Scranton (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Rossauna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalena Laureska

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~ Anthony Laureska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years about 69 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Simon Wilkes
13. Birthplace Lithuania

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant The Seton Institute,
(b) Address 6420 Reisterstown Rd., Balto 15 Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 3 1948 (month) (day) (year)
(c) Cemetery or crematory St. Catherine
Location Moscow - Penna.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. S. Number Six) 100 N. North Avenue

19 (a) (b)
Date rec'd by registrar Registrar
SEP 2 - 1948 Lexington Mausoleum, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1948 to 9-2-48 1948, and that I last saw h~~er~~ alive on 9/2/47 19.

Immediate cause of death — Duration
Cardio - Resp failure

Due to Recurrent carcinoma of the breast and

Due to metastases

Other Conditions arteriosclerotic heart disease and Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Meiers, M. D.
M. D.
Address Seton Institute Date signed 9/4/48

X

66487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll Co
(c) City or town Manchester, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lydia L. Snyder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John W. Snyder deceased
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr): Sept 9, 1865
8. AGE: Years 82 | Months 11 | Days 23 | If less than one day: hr. min.
9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: John W. Greenfield
13. Birthplace: Littlestown, Pa.

MOTHER
14. Maiden Name: Anna Bixler
15. Birthplace: Carroll Co. Md.

16 (a) Informant: Mrs. J. Peter
(b) Address: 1601 Broadway
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory: Cemetery
Location: Manchester, Md
18 (a) Funeral director: Jacob Wm. Bair
(b) Address: Manchester, Md
19 SEP 3 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1948 at 6:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1948 to Sept 2 1948 and that I last saw h[illegible] alive on Sept 2 1948.

Immediate cause of death: Terminal Broncho Pneumonia - due to Senility — Duration: 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature: Ernest Kerr, M.D.
Address 1601 N. Broadway Date signed 9/2/48

VS 150

G66488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G66488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State No. Carolina (b) County GATES
(c) City or town CRAPEAK (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH ANN WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL 4, 1943

8. AGE: Years	Months	Days	If less than one day
5	4	29	hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name NORFLEET WHITE
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden Name DOROTHY BRINKLEY
15. Birthplace NORTH CAROLINA

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 3/48 (month) (day) (year)
(c) Cemetery or crematory Eureka Church Cem
Location N Cgo

18 (a) Funeral director Wells Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 2 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948, to 9-2 1948, and that I last saw HER alive on 9-2 1948.

Immediate cause of death: Brain Abscess — Duration

Due to: Cause Undetermined

Due to:

Other Conditions: Congenital Heart Disease Etiology & Pathogenesis

(Include pregnancy within 3 months of death)

Date of operation Sept 1, 1948

Major findings of operation: Left Frontal Brain Abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address JOHNS HOPKINS HOSPITAL Date signed Sept 2, 1948

VS 150

066489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. 066489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 S PATTERSON PK AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE CATON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed~~, or divorced: Divorced

6 (b) Name of husband ~~or wife~~: Leo Caton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 4th 1892

8. AGE: Years: 56 | Months: 4 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation:
11. Industry or business: at Home

FATHER 12. Name: Chas. Hazlestay
13. Birthplace: Md.

MOTHER 14. Maiden Name: Mary E. Reardon
15. Birthplace: Md.

16 (a) Informant: Mrs. James Hart
(b) Address: 246 E. North Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof: 9/4/48 (month) (day) (year)
(c) Cemetery or crematory: St Mathias
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 E. Fayette St.

19 (a) SEP 3 - 1948 (Date rec'd by registrar) ~~Huntington Williams~~

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/2 1948 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/2 1948 and that I last saw h[illegible] alive on 9/1 1948.

Immediate cause of death: Cardiac and respiratory failure
Due to: Pulmonary tuberculosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature: Louis J. Pratt, M.D.
Address: 900 E. 30th St. Date signed: 9/3/48

VS 159

666490 Kohlman

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

666490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Maryland General 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL ~~RESIDENCE~~ OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Eutaw Place # 17
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ella Gertrude Kohlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ Edward G. Kohlman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1880

8. AGE: Years 67 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name George Suter

13. Birthplace Md.

MOTHER 14. Maiden Name Katherine Kelley

15. Birthplace Ireland

16 (a) Informant Edward G. Kohlman

(b) Address 2015 Eutaw Place

17 (a) Burial (b) Date thereof 9/7/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 E. Fayette St.

19 (a) SEP 3 - 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948 at 7 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/29 1948 to 9/1 1948, and that I last saw h[illegible] alive on 9/1 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebrovascular accident	4 days.
Due to Hypertension Cerebrovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebrovascular accident

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Blaul

Address Maryland General Date signed 9/1/48

G66491 C 74037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G66491 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N. Spring St.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 107d
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/47

8. AGE: Years 1 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Thomas
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Ernestine Booker
15. Birthplace Baltimore Md.

16 (a) Informant Mother
(b) Address absent

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Registrar AUG 25 1948

18 (a) Funeral director [redacted]

(b) Address [redacted]

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1948 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1948 to Aug 6 1948 and that I last saw he alive on 8/6 1948

Immediate cause of death Tuberculous Meningitis — Duration 107 d.

Due to

Due to

Other Conditions Hydrocephalus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. O. Goldenberg M.D.
Address Sydenham Hosp. Date signed 8/12

V S 150

G66492

BCv48-17804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G66492

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write (R), and give town)
(d) Street No. 253 E. Main St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hunt

3 (b) If veteran, name war 0 | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/18/48

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace Univ. Hosp. (Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Donald J. Hunt
13. Birthplace

MOTHER 14. Maiden Name Doris Sees
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 8 1948 (Date received by registrar) Livingston Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1948 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1948 to 8/25 1948 and that I last saw h[illegible] alive on 8/25 1948

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Robert Brown M.D.
Address Univ. Hosp. Date signed 8/26

666493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159½

666493
Registered No.

BC- 48-17960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Linden Ave.
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3343 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Butschky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name George Henry Butschky
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Myrtle L. Johnson
15. Birthplace Balto. Md.

16 (a) Informant George Henry Butschky
(b) Address 3343 Belair Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schon AUG 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 3 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-48 19 at 3 10/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-48 19 to 8-20-48 19 and that I last saw him alive on 8-20-48

Immediate cause of death — Duration

Due to Cardiac Vascular Failure

Due to Prematurity

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas C. Waltz M.D.
Address Md Gen. Hosp Date signed 8/20/48 M.D.

VS 153

BC-48-1645 Kulich

G66494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G66494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr 28 mn

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3323 Virginia Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Infant - not baptized Baby Kulick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-2-48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 28 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Frederick Kulick

13. Birthplace Springfield Mass

MOTHER 14. Maiden Name Mildred Mary Clouse

15. Birthplace Baltimore, Md.

16 (a) Informant Mildred Kulick

(b) Address 3323 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)

(c) Cemetery or crematory St Pauls Cem.

Location Violetsville Md

18 (a) Funeral director Mrs Chas A G Roldc

(b) Address 2327 Edmondson Ave

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948, at 8:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to same day 1948, and that I last saw him alive on 9-2 1948.

Immediate cause of death Respiratory Failure — **Duration**

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. A. Petersen M. D.

Address University Hospital Date signed 9-2-48

VS 150

666495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666495

BR-48-20666

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St. 25
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Monroe Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolina Mildred Kimble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Wht

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-48

8. AGE: Years 6 Months Days If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin Kimble
13. Birthplace Salisbury - Md

MOTHER 14. Maiden Name Gwendolyn Anderson
15. Birthplace Balto - Md

16 (a) Informant Mrs. Gwendolyn Kimble
(b) Address 1125 Monroe Circle

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Johns Hopkins Medical Schoo AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 3 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1948, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31, 1948, to June 6 1948; and that I last saw her alive on June 6, 1948.

Immediate cause of death Pulmonary Edema

Due to Incompletely aerated lungs

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kimmit

Address Sinai Hospital Date signed 8/23/48.

X

SC-48-8618

666496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. 666496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Monument St
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 das
(e) Length of stay in Baltimore (yrs., mos., or days) 2 das

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Portugal St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME James John Stanczyk - Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-48

8. AGE: Years	Months	Days	If less than one day
2 das		2	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James J. Stanczyk - Sr
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Madeline Slowacki
15. Birthplace Balto - Md

16 (a) Informant Mrs Madeline Stanczyk
(b) Address 2002 Portugal St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) SEP 3 - 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 - 1948 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1948 to June 6 1948, and that I last saw him alive on June 6 1948

Immediate cause of death	Duration
Pulmonary edema	
Due to Incompletely aerated lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kennish, M.D.
Address Sinai Hospital, Date signed 8/23/48

666497

4P-18366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666497

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto - 15 (If outside city or town limits, write RURAL and give town)

(d) Street No. 401 Parkway Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Sulsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	wht.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-48

8. AGE: Years | Months | Days | If less than one day 1 hr. min.

NB

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harold Sulsky

13. Birthplace Balto - Md.

MOTHER 14. Maiden Name Yetta Sonnenburg

15. Birthplace Balto - Md

16 (a) Informant Mr. Yetta Sulsky

(b) Address 4014 Parkway Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Licensed Johns Hopkins Medical Schoo AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) Date received by registrar SEP 3 1948 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1948 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1948 to 6/28 1948, and that I last saw her alive on 6/28 1948.

Immediate cause of death Multiple malformations of kidneys and bladder

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence. at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph A. Kevins M. D.

Address Sinai Hospital Date signed 8/23/48

666398

BC-48-15478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 666398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-48

8. AGE: Years	Months	Days	If less than one day
0			2 hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjamin Hurwitz
13. Birthplace Russia - Md.

MOTHER 14. Maiden Name Elna Blumenthal
15. Birthplace New York - N.Y.

16 (a) Informant Elna Hurwitz
(b) Address 3607 Park Heights Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Schoo AUG 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

SEP 3 - 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 9:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1948 to 7-26 1948 and that I last saw h[illegible] alive on 7-26 1948

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Premature labor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kuntz M. D.
Address Sinai Hospital Date signed 8/23/48

666499

BC-48-17607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

✓ 666499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 5 Hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto-24 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1415 Georgian St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Francis Dauses

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/18/48

8. AGE: Years 0 Months Days If less than one day 5 hr. 8 min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Joseph Dauses

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Catherine Angeline Kesler

MOTHER 15. Birthplace Balto - Md

16 (a) Informant Catherine Dauses

(b) Address 415 Georgian St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo AUG 24 1948

Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-18 1948, and that I last saw h[illegible] alive on 8-18 1948.

Immediate cause of death Atelectasis both lungs

Due to Congenital defect in diaphragm with herniation of abdominal viscera into thoracic cavity

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph A. Kmint M.D.

Address Sinai Hosp. Date signed 8/29/48

G66500 — Birth - 48 - 16205 — G66500

BC-48-16205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1270 Jones St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Omlor. OMLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/48

8. AGE: Years | Months | Days: 11 12 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Robert Omlor

13. Birthplace RILTON W. FINNA.

MOTHER — 14. Maiden Name Helen HOLLY

15. Birthplace DAYTON OHIO

16 (a) Informant:

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address Washington Wilkinson, MD

19 (a) SEP 3 1948 (b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/17 1948.

and that I last saw him alive on 8/17 1948.

Immediate cause of death	Duration
Respirations ceased	
Due to Prematurity	
Due to	
Other Conditions Djarrhea, dehydration (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature James W. Bisanar M.D. M. D.

Address University Hosp Date signed 8/17/48

VS 150

666501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

666501

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 10 days

(e) Length of stay in Baltimore (yrs., mos., or days): ? 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town):

(d) Street No.: 632 Gold St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: LLOYD WILSON

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah Wilson

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr): Unknown

8. AGE: Years: ? 52 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Storekeeper

11. Industry or business: Own business

FATHER

12. Name: Leonard Wilson

13. Birthplace: Md.

MOTHER

14. Maiden Name: Lucy ?

15. Birthplace: ?

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7-48 (month) (day) (year)

(c) Cemetery or crematory: Balto Nat Cemetery

Location: Baltimore

18 (a) Funeral director: Va Brookes

(b) Address: 1468 N. Carey St

19 (a) SEP 3-1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1948, at 2:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1948 to Sept. 2 1948, and that I last saw him alive on Sept. 2 1948.

Immediate cause of death: Subarachnoid hemorrhage — Duration: 11 days

Due to:

Other conditions: Hypertensive cardiovascular disease — Duration: Unknown

Due to:

Other Conditions: Diabetes mellitus — Duration: 8 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon

Address: Clinical Director Date signed: 9/3/48 M. D.

VS 150

82a

G66502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G66502
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA
(c) Hospital or institution: MERCY HOSPITAL 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALT.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Gay ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph HERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife UNKNOWN.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/72

8. AGE: Years	Months	Days	If less than one day
75 76	11	1	hr. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation UNKNOWN.
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 24 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 AUG 3 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/48 19 . at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 5 1948 to AUG 15 1948, and that I last saw him alive on AUG 14 1948

Immediate cause of death	Duration
PNEUMONIA	
Due to CEREBRAL thrombosis	
Due to A.C. Cardiovasc. disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Joseph L. Arnold M.D.
Address Mercy Date signed 8/15/48

VS 159

G66503

48-15427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G665503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER UZZLE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			20 hr. 5 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1948 at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester D. Lohnis M.D. M.D.
Medical Examiner
Date signed 7-26-48

G66504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

Registered No. 66504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Poulson or Carl Poulson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School AUG 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948, at 7:30 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH myocardial degeneration and chronic alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rey M.D.
Medical Examiner
Date signed 8/13/48

VS 151

666505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

666505
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Richwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Richwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. Ries

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Andrew E. Ries
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	-	3		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick O'Hara
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Schenfer
15. Birthplace Maryland

16 (a) Informant Andrew E. Ries
(b) Address 525 Richwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St.

19 [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1948, at 10 00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 20, 1948, to Aug 31 1948.
and that I last saw h[illegible] alive on, 19

Immediate cause of death	(1) Acute Congestive Heart Failure	Duration
Due to	(2) Hypertrophy of the heart	
Due to	(3) Dropsy (Severe generalized swelling of the entire body.)	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Manuel Godaro
Address 4624 York Road Date signed Sept 2 48

VS 150

A 66506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 921

Registered No. D66506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Little Sisters of the Poor
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Carr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Edward Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1870

8. AGE: Years 78 | Months 5 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Gibson
13. Birthplace

MOTHER 14. Maiden Name Frances Walters
15 Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1 (month) (day) 48 (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Pius Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1948, to Sept 2 1948, and that I last saw h alive on Sept 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	3 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in public place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 103 E. Centre Date signed Sept 2 48

VS 159

G66507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G66507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ERRORS ALTERED OR ERASED VOID ON BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Kresson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE SHINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1872

8. AGE: Years	Months	Days	If less than one day
76	-	23	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Henry Wachsmuth
13. Birthplace Baltimore County, Maryland

MOTHER
14. Maiden Name Theresa Markel
15. Birthplace Baltimore County, Maryland

16 (a) Informant Mrs. Leach
(b) Address West & Martel Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. McGowan
(b) Address 1639 N. Broadway

19 (a) SEP 3- 1948 (Date received by Registrar) (b) Huntington Holloway, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Novak M.D. Medical Examiner
Date signed 9-3-48

VS 151

G666508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 666508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 E. LAFAYETTE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 E. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SENEY BELL DENNERT

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew R. Dennert

6 (c) If alive, give age: 91 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1861

8. AGE: Years: 86 | Months: 11 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name ? Rhinehardt
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Mr. Andrew R. Dennert
(b) Address: 1807 E. Lafayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Sept 1948.
and that I last saw h[illegible] alive on Augt 31 1948.

Immediate cause of death — Duration
Chronic General Arteriosclerosis — Several Years
Due to Hypostatic Pneumonia — 3 Days
Due to Old age etc
Other Conditions Infirmities 3 yrs Double Cataract - Blind
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Keown M.D.
Address 1938 Linden Ave Date signed 9/3/48

VS 150

G66509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5108 Ardmore Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Ardmore Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN GERRIT KAMPS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-07-7395

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. (Born) Kamps

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1883

8. AGE: Years: 65 | Months: 6 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Kraft Co.

FATHER
12. Name: Gerrit Kamps
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elsie Soth
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna M. Kamps - widow
(b) Address: 5108 Ardmore Way - 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to Sept 2 1948, and that I last saw him alive on Sept 2 1948.

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 5108 Ardmore Rd Baltimore Md. Date signed 9-2-48.

VS 150

6665 BC-40-17696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Sq Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d 2h
(e) Length of stay in Baltimore (yrs., mos., or days) 14d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Johnson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Conaway
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 8/20/48
8. AGE: Years | Months | Days: 14 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leon Conway
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillian Kinsella
15. Birthplace Maryland

16 (a) Informant Leon Conway
(b) Address 1722 Johnson St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie
18 (a) Funeral director James L. Tawney
(b) Address 130 E. Fayette St.
19 (a) SEP 3 - 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1948, at 6:20 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1948, to 9/3 1948, and that I last saw him alive on 9/2 1948.

Immediate cause of death: Respiratory failure
Due to: Prematurity
Due to:
Other Conditions: (include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. W. Christopher M.D.
Address Franklin Sq. Hosp. Date signed 9/3/48

VS 159

G66511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1319

Registered No. G66511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 212 STONEY RUN LANE

(c) Hospital or institution: HILLCREST NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 WKS.

(e) Length of stay in Baltimore (yrs., mos., or days) 61 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 503 BEAUMONT AVE. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME GEORGE SAMUEL LYLES

3 (b) If veteran, name war

3 (c) Social Security Account No 216-10-6701

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MILLIE L. LYLES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	28	hr. min.

9. Birthplace CALVERT CO. MD. (Town, county, and state)

10. Usual Occupation BOOKKEEPER

11. Industry or business

FATHER

12. Name SAMUEL LYLES

13. Birthplace MD.

MOTHER

14. Maiden Name MARY LAWRENCE

15. Birthplace MD.

16 (a) Informant AUGUSTA LYLES

(b) Address 503 BEAUMONT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 4 48 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET

Location BALTO.

18 (a) Funeral director HENRY W. JENKINS & SONS

(b) Address 4905 YORK RD.

19 (a) SEP 3 - 1948 (b) Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd 1948, at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946, to Sept 2 1948, and that I last saw him alive on Sept. 1 1948.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Arteriosclerotic Cardio-Renal disease with	
Due to uremia, terminal.	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howland Edward Day

Address 4-E-33rd St Balto Date signed 9/3/48

VS 130

666512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 Oak Hts. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Dolan (Nolan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If [illegible] give age years

7. Birth date of deceased (mo., day, yr.) 9 - [illegible] -1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Chicken Picker

11. Industry or business

FATHER
12. Name James Nolan
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Mary [illegible]
(b) Address 2515 N. Bradle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. Halstead

18 (a) Funeral director
(b) Address 918 - Druid Hill

SEP 8 1948 (Date received) by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948, at 12 noon M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio sclerotic cardio vascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-29-48

VS 151

G66513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66513 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W. Clement St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tirsa

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James M. Tirsa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 8 ?

8. AGE: Years	Months	Days	If less than one day
? 78	9		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business none

FATHER
12. Name Andrew Sauers
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa ? ?
15. Birthplace Germany

16 (a) Informant Mrs Edna M. Norton
(b) Address 109 W. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Q. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 426 Light St.

19 (a) Date rec'd by registrar SEP 3 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/31 1947 to 9/2 1948, and that I last saw h[illegible] alive on 9/2 1948.

Immediate cause of death Arteriosclerotic C. V. Disease — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G Brenson M. D.
Address 107 E. West St. Date signed 9/3/48

G66514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G66514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Reynolds WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-4103

4. Sex M

5. Color or race C.

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ANNA ELIZABETH

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr) 3-18-1882

8. AGE: Years 66 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Richmond, VA
(Town, county, and state)

10. Usual Occupation PENSIONER

11. Industry or business

FATHER
12. Name ?
13. Birthplace VA.

MOTHER
14. Maiden Name CORNELIA WASHINGTON
15. Birthplace VA.

16 (a) Informant Robert WASHINGTON
(b) Address 817 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md.

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carrollton Ave

19 (a) (Date received by registrar) SEP 8 1948 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1948 to 9/1 1948
and that I last saw h(im) alive on 8/31 1948

Immediate cause of death cerebral hemorrhage — Duration 11 days

Due to hypertensive cardio-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
RAYNER BROWNE, M. D.
Address 1302 EAST MADISON ST. Date signed 9/2/48
BALTIMORE 5, MD.

G66515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G66515

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Dolphin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolinia. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jim Right
13. Birthplace S.C.

MOTHER
14. Maiden Name Ellen Right.
15. Birthplace N.C.

16 (a) Informant Eloise Logan Green
(b) Address 627 Dolphin St.

17 (a) [illegible] (b) Date thereof Sept. 6. 1948
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Calvery Cem.
Location Frdk. Md.

18 (a) Funeral director Elroy O. Filson
(b) Address 1000 Brantly Ave.

19 (a) Sept 8 1948 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2, 1948. at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1948. to Sept 2, 1948. and that I last saw h[illegible] alive on Sept 1, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 W. Hill Ave Date signed 9/2/48

G66516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121C

Registered No. 166516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Edna Rhubottom

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry F Rhubottom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1924

8. AGE: Years: 24 | Months: 3 | Days: 17 | If less than one day: hr. min.

9. Birthplace Sykesville Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Jenkin F Coleman
13. Birthplace Md

MOTHER
14. Maiden Name Ella L. Houston
15 Birthplace Md

16 (a) Informant Harry F Rhubottom
(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory West Liberty Cem
Location Alpha Md

18 (a) Funeral director H. C. Heimbolkam
(b) Address Efficient Md

19 SEP 8 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1, 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-48 19 . to 9-1-48 19 . and that I last saw h[illegible] alive on 9-1-48 19 .

Immediate cause of death Resp. failure — **Duration**

Due to Uremia

Due to Chronic glomerular nephritis & acute exacerbation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John White M. D.

Address University Hosp. Date signed 9-1-48

G66517
GM.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G66517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave:
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 Minuts
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Spring ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29 1918

8. AGE: Years 30 | Months - | Days - | If less than one day hr min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lorenzo. Johnson
13. Birthplace MD.

MOTHER 14. Maiden Name Frances Garner
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery. Cem.
Location Brooklyn. Md.

18 (a) Funeral director Elroy. C. Wilson
(b) Address Brenly. Ave.

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 2- 19 48 at 9.40 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9- 2- 19 48 to 9- 2- 19 48. and that I last saw her alive on 9- 2- 19 48

Immediate cause of death LOBAR
a PNEUMONIA LLL
c pleural effusion

Duration 5 days

Due to

Due to

Other Conditions PELVIC Inflammatory disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia LLL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David h. Maurer M. D.
Address Balto City Hosp Date signed 9-2-48
for C. J. Zubrycki by
Howard J. Maeder M.D.

To Be Approved By Medical Examiner

G66518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66518 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 North Durham Street
(c) Hospital or institution: – None – –
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 112 North Durham Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country – – –

3 (a) FULL NAME CARROLL T. HUMES

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/28/1879

8. AGE: Years	Months	Days	If less than one day
69	6	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Box Factory

FATHER
12. Name John Humes
13. Birthplace England

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Virginia

16 (a) Informant Ruth Trotta
(b) Address 112 North Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/1948 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Horners Lane

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 SEP 3 - 1948 (Date rec'd by Registrar) Huntington Williams, Md Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1948, at 6:45 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6-1948 to Sept 1 1948 and that I last saw him alive on Aug. 30 1948.

Immediate cause of death: Acute Cardiac Failure — Duration: 1½ hours
Due to Arteriosclerotic
Due to Heart Disease — 5 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Israel Kosen M.D. (M.D.)
Address 2413 E Monument St
Sept 2, 1948

666519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Camp Holabird
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. Camp Holabird
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST HIRSCH (Ernest R. Hirsch)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1908

8. AGE: Years 40 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Mannheim Germany (Town, county, and state)

10. Usual Occupation Capt. U. S. Army

11. Industry or business

FATHER
12. Name Theodor Hirsch
13. Birthplace Unknown

MOTHER
14. Maiden Name Klara (Unknown)
15. Birthplace Unknown

16 (a) Informant U.S. Army Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 4 48 (month, day, year)
(c) Cemetery or crematory Fermingdale National
Location Fermingdale L.I. N.Y.

18 (a) Funeral director Lilly and Zeller, Inc.
(b) Address 403 S. Wolfe St. Balto. 31.

19 (a) SEP 3 - 1948 (Date received by registrar) (b) Huntington Williamsport, Md

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/48 19 at 6:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound Head

Due to

Other Conditions Marked depressive State

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following.
(a) Date of injury 8/31 at approximately 6:50 P.M.
(b) Where did injury occur? Camp Holabird
(c) Did injury occur at home, on farm, industrial place, in public place? Army Camp (While at work?) No
(d) Means of injury Self Inflicted 7.65 mm. Revolver

23. Signature John R Davis M.D.
Medical Examiner

Date signed 9/1/48

666520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. 666520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Ave & Kenwood Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Bloomsbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Virginia Rappamier MRS. VIRGINIA M. RAPPAMIER

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Christopher

6 (c) If alive, give age 93 years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1857

8. AGE: Years 91 | Months 6 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business House wife

FATHER 12. Name Andrew Basaker

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Pfeifer

MOTHER 15. Birthplace Maryland

16 (a) Informant Frank O. Rappamier

(b) Address Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1948 (month) (day) (year)

(c) Cemetery or crematory St. John's

Location Howard Co.

18 (a) Funeral director Edward F. McNabb

(b) Address Catonsville Md

19 SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Indiana

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1948 to 9/1 1948 and that I last saw her alive on 9/1 1948.

Immediate cause of death CARDIO-RESPIRATORY FAILURE

Due to SENILITY

Due to CACHEXIA

Due to ARTERIO SCLEROSIS

Due to CARCINOMA OF CECUM

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clinton B. Hess M. D.

Address [illegible] Date signed 9/2

VS 199

G66521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

G66521 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Frank Dale) FRED DOLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Franklin Va
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace " "

MOTHER 14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant James Coleman
(b) Address 1339 E. Lombard St

17 (a) Burial (b) Date thereof 8-4-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Franklin Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave Washington-Williamson Mortuary

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/09 1948, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-28-48 at 9:00 P.M.
(b) Where did injury occur? 1433 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Heat stroke

23. Signature C. P. Telinde M.D.
Medical Examiner.
Date signed 8/29/48

VS 151

G666522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G666522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline St.
(c) Hospital or institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Mr. William B. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 13, 1892

8. AGE: Years 55 | Months 8 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name Harmon Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Black
15. Birthplace Md.

16 (a) Informant Irene Starka
(b) Address 1306 Green Mount Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (c) Date received SEP 4 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1948 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1948 to Sept. 2, 1948, and that I last saw him alive on Sept. 2, 1948.

Immediate cause of death: Carcinoma of stomach with metastasis to liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of Stomach with metastasis to liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Pearson Jr. M.D.
Address St. Joseph's Hospital Signed 9/2/48

VS 150

G66523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66523 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Fadum

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-9704

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna G. Fadum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1883

8. AGE: Years	Months	Days	If less than one day
64	8	11	12 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Women's Dept. Store

FATHER 12. Name Frederick Fadum

13. Birthplace Germany

MOTHER 14. Maiden Name Louise Albrecht

15 Birthplace Md.

16 (a) Informant Mrs. Anna G. Fadum

(b) Address 1716 E. 31st St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 4-48 (month) (day) (year)

(c) Cemetery or crematory St Paul's Druid Hill Park

Location Druid Hill Park

18 (a) Funeral director Williams Cook Inc.

(b) Address 217 St Paul St.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1948, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 48 to Sept 2 19 48, and that I last saw him alive on Sept 1 19 48.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Arterio-Sclerosis - Chronic Nephritis → 3 mos.

Due to Nephritis - contracting Chronic cystitis → 1938 Op.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Uretero Sac Bladder; adhesions Omental of autopsy: Nephritis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. N. Rosa Jr.

Address 1522 E 33rd Date signed 9/3/48

G66524

M175651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G666524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) 12
(d) Street No. No Home. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonsus Hasenkamp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1873

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anton Hasenkamp
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Baker
15. Birthplace Germany

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 1940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Laurel Lawn
Location Germantown Hill Rd.

18 (a) Funeral director John T. Taylor Sons
(b) Address 1368 Light St.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31- 19 48 7:25 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 19 42 to 8-31 19 48 and that I last saw h. alive on 8-31 19 48

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to

Due to

Other Conditions: Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Rackold
Address Balto City Hosp. Date signed 9-3-48

VS 150

107

Mrs. S. Pamelia Kirwan

G666525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH PAMELIA KIRWAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Edgar F. Kirwan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Nov. 20, 1860

8. AGE: Years: 87 | Months: 9 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George E. Greenwood
13. Birthplace: Kent Co.

MOTHER
14. Maiden Name: Martha C. Rutter
15. Birthplace: Cecil Co., Md.

16 (a) Informant: Mrs. Grace Breeden
(b) Address: 2404 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1948, at 11:10 M P

21. I certify that death occurred on the date above stated, that I attended deceased from June 1, 1947, to Sept. 2- 1948, and that I last saw h alive on Sept 2- 1948.

Immediate cause of death: Cardiac failure
Pulmonary edema,
Due to Cardiovascular
Renal disease
Due to Arteriosclerosis.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
15 mo
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Greenwood M. D.
Address 28 W 25th St. Date signed 9-3-48

G666526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G666526 Registered No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Pier #6 Pratt St.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Middlesex
(c) City or town Wake
(If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (djm) JOHN HENRY (GRINELL) GRINELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy F. Grinels

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): June 3, 1885

8. AGE: Years: 63 Months: 2 3 Days: If less than one day: hr. min.

9. Birthplace: Middlesex County, Va.
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business: self

FATHER
12. Name: John Parker Grinels
13. Birthplace: Middlesex County, Va.

MOTHER
14. Maiden Name: Irene Harrow
15. Birthplace: Middlesex County, Va.

16 (a) Informant: William F. Grinels
(b) Address: 613 Norwood Avenue Richmond, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-5-48 (month) (day) (year)
(c) Cemetery or crematory: Middlesex County, Va.
Location

18 (a) Funeral director: Wm. J. Tuhman & Son
(b) Address: 700 E. Franklin Ave.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1948, at 6:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: Found: 9-3-48 at 6:30 A M.
(b) Where did injury occur? Found: Pier #6--Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury: Found drowned

23. Signature: [signature] M.D.
Medical Examiner.
Date signed 9-3-48

G66527 27 61 G66527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Bryant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Lipsitz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Late Celia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1873
8. AGE: Years 75 Months 74 Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Benjamin Lipsitz
(b) Address 2312 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 SEP 4 - 1948 (Date rec'd by registrar) Huntington Williams (Signature of registrar)

VS 159

MEDICAL CERTIFICATION

10:50

20. DATE OF DEATH September 3 1948 at A. M
21. I certify that death occurred on the date above stated; that I attended deceased from JAN 21 1947 to Sept 3 1948 and that I last saw him alive on Sept 3, 1948

Immediate cause of death	Duration
CARDIO - RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE	
Due to HYPERTENSIVE CVH D. GENERALIZED ARTERIOSCLEROSIS	
Other Conditions DIABETES MELLITUS	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leland Carpenter M.D.
Address 25 W Read St Balto Md Date signed 9/3/48

93

G66528
11234

18

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55c

Registered No. G66528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rochester Apts. 1E (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Liegel

3 (b) If veteran, name war WORLD WAR I

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-27-94

8. AGE: Years 53 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Lazio Liegel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Leavitt
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept 5 1948 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 N. North Ave

19 (a) SEP 4 - 1948 (Date received by registrar) **(b)** Lexington Williams M.D.

MEDICAL CERTIFICATION

30

20. DATE OF DEATH Sept. 2 1948 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Sept 2 1948 and that I last saw h[illegible] alive on Sept. 2 1948

Immediate cause of death (1) Hemorrhage, massive, intrapulmonary, secondary to (2)
Due to (3) Carcinoma of thyroid, c[illegible] peritracheal metastases
Due to [illegible]

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E Ehrman M. D.
Address JOHNS HOPKINS HOSPITAL **Date signed** 9-2-48

VS 150

G666529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G666529
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Ave., Rivera Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ALLEN LITCHFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Viola R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1901

8. AGE: Years	Months	Days	If less than one day
47	7	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business (Self)

FATHER
12. Name William E. Litchfield
13. Birthplace Balto.

MOTHER
14. Maiden Name Virginia Roland
15. Birthplace Balto.

16 (a) Informant Mrs. Viola Litchfield
(b) Address 2309 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto. Md.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 4 - 1948 (Rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 3 PM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed

G66530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4046 Hillen Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4046 Hillen Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Roben

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25.1859

8. AGE: Years	Months	Days	If less than one day
89	1	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Gerhardt Roben
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant MissAmelia Smith
(b) Address 4046 Hillen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.5/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Chilis Henrig Sons
(b) Address 2024 Orleans St.

19 SEP 4 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.3/48 19 . at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept. 3 1948.
and that I last saw h alive on Sept. 3 1948

Immediate cause of death	Duration
Cardio vascular	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson White M. D.
Address 3005 St. Paul St., Date signed 9-4-48

VS 189

G66531 BC: F852x8 BALTIMORE CITY HEALTH DEPARTMENT 31 ✓ G666531 Registered No.

CERTIFICATE OF DEATH

18 6a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 853 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MASTER - WALTER E. MATTHEWS. JR

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 st, 1943

8. AGE: Years 4 | Months 11 | Days 13 | If less than one day hr. min

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Walter E. Matthews
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary E. Sellers
15. Birthplace Baltimore Md.

16 (a) Informant Mr Walter E. Matthews
(b) Address 853 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John G. Cowan & Son
(b) Address 901-03 Hollins St.

19 SEP 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Sept. 48 1948. at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Sept 1948 to 3 Sept 1948. and that I last saw h/ m alive on 3 Sept 1948.

Immediate cause of death: Intraventricular hemorrhage — Duration 18 hrs.
Due to Head Trauma
Due to
Other Conditions Intracerebral hemorrhage — 18 hrs
(Include pregnancy within 3 months of death)

Date of operation 2 Sept. 48
Major findings of operation: Intracerebral & intraventricular hemorrhage
autopsy:

PHYSICIAN Underline the cause to which should be charged statistically.

22. If death was due to external causes, fill in the following: 21/3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2 Sept. 48 at 3:30 P M
(c) Where did injury occur? 853 W.B. Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No
(Specify type of place)
(e) Means of injury Fell in yard

23. Signature Edward H. Smith M D
Address University Hospital Date signed 3 Sept 48

S. Mrs. G. Hilford, by Thomas T. Mellon, M.D. Baltimore Md. X

VS 150

666532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MUSGOE FAUNTLEROY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Fannie Fauntleroy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884.

8. AGE: Years 64 | Months | Days | If less than one day: hr. min

9. Birthplace Essex County, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lawrence Fauntleroy

13. Birthplace Essex County, Va.

MOTHER 14. Maiden Name Emily

15. Birthplace Virginia

16 (a) Informant Norman Brown

(b) Address 228 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month, day, year)

(c) Cemetery or crematory Mt. Auburn.

Location

18 (a) Funeral director Mrs Katie A. Ellis

(b) Address 322 N. Schroeder St.

19 (a) SEP 4 1948 (Date rec'd by Registrar) (b) Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 2, 1948, at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl L Royer M.D. Medical Examiner

Date signed 9-4-48

VS 151

666533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Odell Burton (Spell)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female
5 Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Jonny Spell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-10

8. AGE: Years 38 | Months | Days 17 | If less than one day: hr. min.

9. Birthplace No. Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name O. Burton
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Mamie Fuller
15. Birthplace So Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 SEP 4 - 1948 (Date rec'd by local registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948, to 9/1 1948, and that I last saw her alive on 9/1 1948.

Immediate cause of death Uremia — Duration

Due to nephrosclerosis

Due to Essential Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
Means of injury

23. Signature Sherman Mellnikoff
Address JOHNS HOPKINS HOSPITAL Date signed 9-6-48

VS 150

G66534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

34 V 83a

Registered No. G66534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 14
(e) Length of stay in Baltimore (yrs., mos., or days) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Brunt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Greenwell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Separated
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1885
8. AGE: Years 63 | Months | Days | If less than one day hr. min.
9. Birthplace md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jim Greenwell
13. Birthplace md

MOTHER
14. Maiden Name Mary Summerville
15. Birthplace md

16 (a) Informant Elizabeth Green
(b) Address 1825 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location md

18 (a) Funeral director George R. Nelson
(b) Address 1302 Presstman St

19 (a) Signature of embalmer Huntington Williams Supt

SEP 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1948, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1948 to 9-1 1948, and that I last saw him alive on 9-1-48 1948.

Immediate cause of death: Coronary thrombosis (Morbid)
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Brady
Address Provident Hosp Date signed 9-3-48

G66535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G66535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 N. Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY LOUISE REEDER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: John E. Reeder
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1866
8. AGE: Years 82 | Months 6 | Days 2 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Wineke
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Plunkett
15. Birthplace: Ireland

16 (a) Informant: Miss Nettie T. Reeder
(b) Address: 1123 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Sept 3 1948.
and that I last saw her alive on Sept 2nd 1948

Immediate cause of death uraemia — Duration 2 days

Due to Chr. nephritis + — 2 years

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Poplar Grove St Date signed 9/3/48

G66536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH -13B

Registered No. G66536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 321 E. North Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 321 E. North Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAZEL C. RAPPAPORT

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louis C. Rappaport

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 31, 1904

8. AGE: Years 44 | Months 3 | Days 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael E. Healy
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Katherine McAulliffe
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Zilda C. Glass, sister

(b) Address: 838 N. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)

(c) Cemetery or crematory: Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) (b) Turlington N. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1945 to Sept 3 1948. and that I last saw her alive on Aug 6 1948

Immediate cause of death: Carcinoma Pulmonary — Duration

Due to

Due to

Other Conditions: Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Jack J. Singer M D

Address 5062 Northern Pkwy Date signed 9-4-48

666537 HEALTH DEPARTMENT—CITY OF BALTIMORE 666537

CERTIFICATE OF DEATH

1. PLACE OF DEATH Crawford Retreat — Registered No. 927

CITY OF BALTIMORE: (No. 2117 Dennison St. 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Albert H Bowen — If U.S. Veteran specify WAR

(a) Residence: No. 817 Beaumont Ave. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Nov. 1, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	10	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Albert M. Bowen

14. BIRTHPLACE (city or town) (State or country) Balto., Md.

MOTHER

15. MAIDEN NAME Juliet Hewell

16. BIRTHPLACE (city or town) (State or country) Balto., Md.

17. INFORMANT (Address) Mr. Clarence Bowen, 817 Beaumont Ave.

18. BURIAL, CREMATION, OR REMOVAL Place Woodlawn Cem. Date 9/6/48

19. UNDERTAKER (Address) M. J. TICKNER & SONS, Balto., Md.

20. FILED SEP 4 - 1948 Registrar: Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 3, 1948

22. I HEREBY CERTIFY, That I attended deceased from June 5, 1948 to Sept. 3, 1948

I last saw him alive on Sept 2, 1948 Death is said to have occurred on the date stated above, at 4 P m.

The principal cause of death and related causes of importance were as follows:

Myocardial Insufficiency — Date of onset 7-31-48

Hypertensive Cardiovascular Disease — Duration

Other contributory causes of importance:

Paralysis of left leg & Arm due to Cerebrovascular accident — 1yr

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury ... 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A Bradley Dewhurst M. D.

(Address) 1364 Francis Ave. Balto 27

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

VR 3

G66538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 B

Registered No. G66538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Glenmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED GERMAN THEODORES

3 (b) If veteran, name war NO

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nels H. Theodores

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1903

8. AGE: Years 45 | Months 5 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Baltimore Public School

FATHER
12. Name Wm. H. Davis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Grace German
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Nels H. Theodores
(b) Address 3315 Glenmore Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 4 - 1948 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948 at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 1946 to Sept 2 1948 and that I last saw h[illegible] alive on [illegible] 1948.

Immediate cause of death Carcinoma
[illegible] Lumbo-Dorsal vertebrae

	Duration
	30 mo

Due to

Due to

Other Conditions Accelerated Paralysis Ileus
Surgical
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lillian E Little M. D.

Address 12 W. Madison St Date signed 9-3-48

VS 180

G66539 BC-148-14557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66539 Registered No. 160c

AB-122532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Tate St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Wimmy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29-1948

8. AGE: Years | Months | Days | If less than one day: hr. 20 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Wimmy
13. Birthplace Ga.

MOTHER
14. Maiden Name Mabel Mason
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-31-48 At 9.00 A M (month) (day) (year)
(c) [redacted] crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 SEP 4 - 1948 (Date rec'd by registrar) Lutington Williams, M.D.

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29- 1948, at 3.10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-29- 1948 to 8-29 1948, and that I last saw her alive on 8-29- 1948.

Immediate cause of death
Primary atelectasis immediate
Spasm of Larynx
Due to Bronchus Contracted Pelvis

Duration 43 Min

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Mid Forceps delivery

Major findings of operation:

of autopsy: Dr. Lutas, Abigail Hamm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 414 Eastern Ave Date signed 8/31/48

066540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V. 112

Registered No. 066540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew CHAMBERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife: Ardelia Chambers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1922

8. AGE: Years	Months	Days	If less than one day
26	7	6	hr. min.

9. Birthplace: Cleveland Co., N. C. (Town, county, and state)
10. Usual Occupation: Truck Driver
11. Industry or business: Wholesale Grocery

FATHER
12. Name: Rufus Chambers
13. Birthplace: York, South Carolina

MOTHER
14. Maiden Name: Lizzie Good
15. Birthplace: York, South Carolina

16 (a) Informant: Lizzie Chambers
(b) Address: Shelby, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory: Ellis Chapel
Location: Shelby, N. C.

18 (a) Funeral director: Chas. R. Law
(b) Address: 802 Madison Ave

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Lexington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 12:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/9/48

G66541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 942 Stoddard Court
(c) Hospital or institution:
(d) Length of stay in hospital or ins. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 942 Stoddard Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES CURTIS JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Deborah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 1, 1886

8. AGE: Years: 62 | Months: 3 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Long Green, Maryland. (Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business

FATHER
12. Name: James W. Jones
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Eliza Quickley
15. Birthplace: Maryland.

16 (a) Informant: Mrs. Mary D. Jones
(b) Address: 942 Stoddard Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Maryland.

18 (a) Funeral director: Thos. George & Sons
(b) Address: 1601 Druid Hill Ave.

19 (a) Filed: SEP 8 1948 (b) Registrar: Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/1948 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1948 to 9/3 1948 and that I last saw h[illegible] alive on 9/2 1948.

Immediate cause of death: Intestinal Carcinoma (Colon)

Duration: 8-10 mos.

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Proctor Grant, M. D.
Address: 6601 N. Carroll Ave. Date signed: 9/2/48

G66542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G66542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 South Robinson Street
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 South Robinson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ROMANSKI

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Francis Romanski

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr) 11/15/1873

8. AGE: Years 74 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name John Bialozenski
13. Birthplace ?

MOTHER
14. Maiden Name Josephine ?
15. Birthplace ?

16 (a) Informant Bernard Romanski
(b) Address 431 South Robinson Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1901 Eastern Avenue Balto. 31

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

SEP 4 - 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948, at 6:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 3 1948 and that I last saw h[illegible] alive on Sept 3 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 hrs.

Due to previous attack of Coronary Thrombosis — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.

Address 3218 Eastern Ave Date signed 9-4-48

G66543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G66543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2534 Mc Cullok St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 Mc Cullok St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola J. Phillips

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James Phillips | 6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1900

8. AGE: Years 47 | Months 10 | Days 5-6 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Irvin Perry
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lila Morris
15. Birthplace Balto Md

16 (a) Informant James Phillips
(b) Address 2534 Mc Cullok St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/48 (Month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem Co
Location A A Co Md

18 (a) Funeral director Isaiah A Brandon
(b) Address 1846 Montgomery St

19 (a) Date received SEP 4 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1948, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948, to Sept 2 1948, and that I last saw her alive on Sept 2 1948.

Immediate cause of death Carcinoma of Breast — Duration 8 yrs

Due to Metastases — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 9/7/48

G66544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G66544
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 454 Duncan St.
(c) Hospital or institution: Baltimore Md
(d) Length of stay in hospital or inst.: (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife: Nettie Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	3	22		

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Farming
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nettie Butler
(b) Address Woodbine, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Woodbine, Md.
Location

18 (a) Funeral director Hunter & Keyes
(b) Address Woodbine, Md.

19 (a) 1948 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-1948 at 4 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8-3-48 to 9-4-1948 and that I last saw deceased alive on 9-4-1948

Immediate cause of death (Pulmonary edema) (edema of lungs)

Due to Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underlying the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Brady M.D.
Address Woodbine, Md. Date signed

G66545

412677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66545 Registered No.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County.
(c) City or town HARLAN, (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney BARNES Douglass

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife BRUNWEN — 6 (c) If alive, give age ?years

7. Birth date of deceased (mo., day, yr) NOV. 16 1884

8. AGE: Years	Months	Days	If less than one day
63	9	18	hr. min.

9. Birthplace Ky (Town, county, and state)
10. Usual Occupation Manager Wholesale -
11. Industry or business Grocery

FATHER 12. Name Jesse Douglas
13. Birthplace Ky

MOTHER 14. Maiden Name Florence [illegible]
15. Birthplace Ky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 4 '48 (month) (day) (year)
(c) Cemetery or crematory REST HAVEN
Location HARLAN KENTUCKY

18 (a) Funeral director Henry H Wiggs
(b) Address 410 Edmondson Ave

SEP 6 - 1948 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 4 - 1948 at 1 25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19 and that I last saw him alive on 9-4 1948.

Immediate cause of death: Intracerebral hemorrhage, left — Duration

Due to Panhematocytopenia, type undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Norman C Stevens M D
Address JOHNS HOPKINS HOSPITAL Date signed 9-7-48

G66546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 952

Registered No. G66546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Northgate Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1530 Northgate Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Aloyse Litz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1894

8. AGE: Years	Months	Days	If less than one day
54	2	23	26 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry G. Litz
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Loretta A. Foige
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Gordon P. Litz
(b) Address 1530 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) Date received (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 3rd 1948, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 1st 1948 to SEPT. 3rd 1948, and that I last saw h[illegible] alive on SEPT. 1st 1948.

Immediate cause of death PULMONARY EDEMA — Duration 1 hour

Due to CONGESTIVE HEART FAILURE — Duration SEVERAL MONTHS

Due to CHR. RHEUMATIC HEART DISEASE — Duration MANY YEARS

Other Conditions NONE

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ferdinand E. Thatch, M. D.
Address 1300 N. Calvert St., Balto. 2, Date signed 9-3-48

G66547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G66547

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St 1511

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3300 Liberty Heights Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SALLIE LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Nathan D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Poland

MOTHER 14. Maiden Name Not Known

15. Birthplace Poland

16 (a) Informant Dr. I. W. Lewis

(b) Address 3300 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem

Location

18 (a) Funeral director Isaac Lewis Inc.

(b) Address 2120 Eutaw Place

19 (a) SEP 5 1948 (Date rec'd by registrar) (b) Huntington 11 (Registrar's No.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1948 to Sept 3 1948, and that I last saw her alive on 9-3 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Arteriosclerotic H.D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Korf M.D.

Address Sinai Hosp Date signed 9-3-48

VS 180

G66548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1740 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 E Chase St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Jessie M. Deffinbaugh (Deffenbaugh)

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-5265

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W	Widowed

6 (b) Name of husband or wife Geo. Wolfinger Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-30-1867

8. AGE: Years	Months	Days	If less than one day
81	7	—	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie Deffinbaugh
13. Birthplace

MOTHER
14. Maiden Name Sarah L Sligh
15. Birthplace Penna

16 (a) Informant John Deffinbaugh
(b) Address 1740 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Patterson Park
Location Balto Md

18 (a) Funeral director Leonard Bill Funeral Home
(b) Address 1221 Eastern Ave

19 (a) (Date) 1945 registrar Huntington Williams M.D.

SEP 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945 at 11 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 19 45 to Sept 2 1945.
and that I last saw h[illegible] alive on Sept 1 1945.

Immediate cause of death Cachexia from Metastatic Carcinoma

Duration 2 yrs

Due to Carcinoma of Colon

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Leonard Bill M.D.
Address 1221 Eastern Ave Date signed 9/3/1945

G66549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 96

G66549
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County
(c) City or town Racine (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 N. Chathan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gunnet Jensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Elizabeth Jensen
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 4-5-99

8. AGE: Years	Months	Days	If less than one day
49 yrs			hr. min.

9. Birthplace Denmark (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marinus Jensen
13. Birthplace Denmark

MOTHER
14. Maiden Name Pengto Person
15. Birthplace Sweeden

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Mound Cem (b) Date thereof Sept 6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mound Cem
Location Racine Wis

18 (a) Funeral director Uelmen Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) (b) Registrar's signature

SEP 8 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 4 - 1948 at 5 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 4 1948.
and that I last saw him alive on Sept 4 1948.

Immediate cause of death	Duration
Ruptured aneurysm Circle of Willis	
Due to Cerebral Hemorrhage	
Due to Congested	
Other Conditions	

(include pregnancy within three months of death)

Date of operation Sept 4 1948

Major findings of operation: Bleeding aneurysm

of autopsy: Ruptured aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify place)
(e) Means of injury

23. Signature [illegible] M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Sept 8

G66550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G66550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 S. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Poland

3 (a) FULL NAME Maryanna Spioch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Spioch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Gerwazzia Spioch
(b) Address 509 S. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 6 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) [illegible] (Registrar) (b) [illegible]

MEDICAL CERTIFICATION 820

20. DATE OF DEATH Sep 3 1948, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 June 1948 to 3 Sep 1948, and that I last saw her alive on 1 Sep 1948

Immediate cause of death: Cardiac failure — Duration: 2 da.

Due to: Cardiac hypertrophy & dilatation — 1 mo.

Due to: Arteriosclerotic C-V disease

Other Conditions: Aortic stenosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd
Address 2601 Eastern Ave. Date signed 3 Sep. 48 M. D.

G66551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

G66551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Edward Kell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Barr Kell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1926 ?

8. AGE: Years 22 | Months 0 | Days 6 | If less than one day 13 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name Truman Kell
13. Birthplace Baltimore

MOTHER
14. Maiden Name May Kell
15. Birthplace Unknown

16 (a) Informant Florence Barr Kell
(b) Address 505 S. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month, day, year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Ave

18 (a) Funeral director Edward Toulson
(b) Address 239 Gurley Blvd

19 (a) Date received by registrar SEP 3 1948 (b) by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 4:15 PM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 3/48 Approx. 3:30 P.M.
(b) Where did injury occur? 505 S. Vincent St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Gas hose in mouth

23. Signature Edward L. Roze M.D.
Medical Examiner
Date signed 9/4/48

VS 181

G66552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

Registered No. G66552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Pr. Geo.
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Richard Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Ollie Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1887

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Pr. Geo Co Md
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Richard Hawkins
13. Birthplace Pr. Geo Co Md

MOTHER
14. Maiden Name Rachel Higgs
15. Birthplace Pr Geo Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 8 45 (month) (day) (year)
ASCENSION
(c) Cemetery or crematory Crawford
Location Bowie Md

18 (a) Funeral director Martin Hardesty & Son
(b) Address Bowie Md

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

Burington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 1:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 9-4 1945, and that I last saw him alive on Sept 1945.

Immediate cause of death	Duration
Congestive heart failure Hydrothorax	
COMMUNICATING HYDROCEPHALUS	
Due to Cerebral Neoplasm	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 9/4/45

G66553

A 6497 64

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1236

Registered No. G66553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MAINE. (b) County
(c) City or town STANKS, (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D.Y. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Gayle Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-22-43

8. AGE: Years	Months	Days	If less than one day
4 5	11	13	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert Hall
13. Birthplace Ky.

MOTHER 14. Maiden Name Eleanor Preston
15. Birthplace Ky.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 5/48 (month) (day) (year)
(c) Cemetery or crematory Ashland Ky
Location same

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2008 Orleans St

19 (a) (Signature of Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-5- 1948 at 12 4½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22- 1948 to 9-5- 1948 and that I last saw her alive on 9-5- 1948.

Immediate cause of death Respiratory Failure — Duration: 3 wks

Due to Uremia — Duration: 5 yrs

Due to Renal Insufficiency

Other Conditions Renal rickets, Renal Rickets

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 9-5-48

G66554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G66554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct [illegible] especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Lexington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rose E. L. King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, ~~widowed~~ or divorced Widowed

6 (b) Name of husband ~~Richard~~ Richard N. King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-64

8. AGE: Years 84 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Henry Sumwalt

13. Birthplace

MOTHER 14. Maiden Name Martha Mules

15. Birthplace

16 (a) Informant W. W. Hoopes

(b) Address 1715 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Green Mount

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) [illegible] (b) [illegible] Registrar

(Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Sept. 3 1948 and that I last saw her alive on Sept. 3 1948.

Immediate cause of death Heat Exhaustion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

~~Major findings of operation~~: generalized Arteriosclerosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry H. Saltzman M. D.

Address Hagerstown Md. Date signed 9-3-48

191

G66555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 432a

G66555
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation of physicians is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Stevenson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband John Stevenson
6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.) Sept 8th 1870

8. AGE: Years	Months	Days	If less than one day
77	11	25	hr. min.

9. Birthplace Ayr, Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Archibald King
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Pollock
15 Birthplace Scotland

16 (a) Informant Elizabeth Coates
(b) Address 636 W. North Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

SEP 6 - 1948
SEP 7 1948
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1948, at 8 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1948 to Sept. 3 1948 and that I last saw her alive on Sept. 3 1948

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Cerebral Hemorrhage	6 (6) hr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl H. Bauman, M.D.
Address 5111 York Rd Date signed Sept. 4, 1948

G66556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G66556 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 HAMILTON Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. UNITY ELIZABETH AARON DORRELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	White	

6 (b) Name of husband or wife DECEASED 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1868

8. AGE: Years	Months	Days	If less than one day
79	9	11	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name John Thomas AARON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Mary ELIZABETH McGRAW
15. Birthplace MARYLAND

16 (a) Informant DAUGHTER (Mrs Helen MANN)
(b) Address 3417 HAMILTON Ave, BALT, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

Filed by registrar Huntington Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1948 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1948 to Sept 3 1948, and that I last saw h e alive on Sept 3 1948.

Immediate cause of death	Duration
PULMONARY Edema	
Due to CARDIAC FAILURE	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Other Conditions 2 days post op for perforated Sigmoid diverticulum (Include pregnancy within 3 months of death)	
Date of operation Aug. 30, 1948	
Major findings of operation: Generalized peritonitis from perforated diverticulum	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Dalton E. Clemens M.D.
Address Union Memorial Hospital Date signed 9/3/48

X

G66557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G66557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 W. Garrison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE SOBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation —

11. Industry or business Housewife

FATHER 12. Name Samuel Solomon

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Sarah ?

MOTHER 15. Birthplace Russia

16 (a) Informant Nathan Sober

(b) Address 3610 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 6 48 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cong

Location Southern Avenue

18 Funeral director Sol Levinson & Bro

(b) Address 112-4-26 W. North Avenue

19 (a) [illegible] (b) [illegible] (Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1948 to 9-5 1948 and that I last saw her alive on 9-5 1948

Immediate cause of death Cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 9-5-48

VS 150

G666558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G666558

Registered No. 112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-28

(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 3609 Clarinth Rd, Balto. 15 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Geltman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	married

6 (b) Name of ~~husband or~~ wife Evelyn R. Royfen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-1906

8. AGE: Years	Months	Days	If less than one day
42	5	5	hr. min.

9. Birthplace Memphis, Tennessee (Town, county, and state)

10. Usual Occupation Service Station Operator

11. Industry or business

FATHER 12. Name Abraham Geltman

13. Birthplace Russia

MOTHER 14. Maiden Name Mary Frieman

15. Birthplace Russia

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Rd., Balto 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jacob Lewy Inc

(b) Address 200 Eastern Place

Baltimore, Md.

SEP 6 1948 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 8/11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 9/5 1948 and that I last saw h~~im~~ alive on 9/5 1948

Immediate cause of death Cardio-Respiratory Failure — Duration —

Due to Bronchial Asthma — 24 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irwin Cohen M.D.

Address Seton Institute Date signed 9/5/48 M D

X

666559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

666559
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Lo Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LENA ISAACSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1873

8. AGE: Years: 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

MOTHER / FATHER
12. Name: Lenger
13. Birthplace: Russia
14. Maiden Name: Kurzak
15. Birthplace: Russia

16 (a) Informant: Abraham Isaacson
(b) Address: 11 Lo Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-6-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd + Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 3100 Eastern Place

19 (a) 1948 (Date rec'd by registrar) (b) Clayton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948 at abt 10 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from DOA to 19 , and that I last saw h. alive on 19 .

Immediate cause of death: Myocardial Insufficiency — Duration

Due to: Arteriosclerotic heart disease

Due to: Sore Rheumatoid H D

Other Conditions: Pulmonary Edema + Congestion

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Judith Landau M D
Address: Sinai Hosp Date signed: 9/5/48 M. D.

VS 150

G66560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G66560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3557 THIRD STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OTTO W. SCHOMAKER (Otto W. Schomaker)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Katherine E. Schomaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 16, 1890

8. AGE: Years	Months	Days	If less than one day
58	5	19	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Stevedore Foreman
11. Industry or business

FATHER
12. Name John Schomaker
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Scholle
15. Birthplace Germany

16 (a) Informant Mrs. Otto W. Schomaker
(b) Address 3557 Third St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd) (Registrar) (b) (Registrar)

SEP 6 1948

OS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 9/5 1948, and that I last saw h[im] alive on 9/5 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6 days

Due to PREFRONTAL LOBOTOMY FOR INTRACTABLE PAIN

Due to CANCER of BLADDER

Other Conditions Uremia & Debility due Cancer of bladder

(Include pregnancy within 3 months of death)

Date of operation 8/30/48 & 9/4/48

Major findings of operation: Edematous brain, hemorrhagic cortex

of autopsy: Unsatisfactory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Lanahan M.D.
Address Sinai Hospital Date signed 9/6/48

X

G66561

BALTIMORE [illegible] LTH DEPARTMENT

CERTIFICATE OF DEATH 166

G66561
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 860 W. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (PARRELL PEARSON) PONIER GUNTHROP PEARSON (d.m)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1933

8. AGE: Years	Months	Days	If less than one day
14	10	27	hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Attended School

11. Industry or business

FATHER
12. Name Deming Pearson
13. Birthplace S. C.

MOTHER
14. Maiden Name Eugenia Gunthrop
15. Birthplace S. C.

16 (a) Informant Eugenia Pearson
(b) Address 860 W. Fairmount Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month, day, year)

(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director A. Hall
(b) Address 918 Druid Hill Ave

SEP 6 1948 [illegible] Registrar
(Date received) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 9:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet-wound of right kidney.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-48 at Approx. 8:30 A M.
(b) Where did injury occur? 612 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? a home (While at work?) No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9-1-48

G66562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G66562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 W. Belvedere Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Tom Wilson

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 02-451-011

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Father Mac Wilson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Jan 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	7	6	— hr. — min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Walter J. Wilson
13. Birthplace England

MOTHER
14. Maiden Name Annie Sands
15. Birthplace England

16 (a) Informant (Patient's administrator)
(b) Address —

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodmere
Location Huntington, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 6 1948
Date rec'd by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948, to Sept. 4 1948, and that I last saw him alive on Sept. 4 1948.

Immediate cause of death	Duration
Uremia	
Due to Long Time Heart failure	
Due to A S C D	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: A S general

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify which place) While at work?
(e) Means of injury —

23. Signature Glenn P. Brown M.D.
Address Union Memorial Hosp Date signed 9/6/48

92

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County Washington
(c) City or town Pelham Manor Gardens (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. DONAHUE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 060-05-1690

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Eglae L. Donahue

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 10, 1880

8. AGE: Years: 68 | Months: 4 | Days: 25 | If less than one day: hr. min.

9. Birthplace: New York (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: BERNARD DONAHUE
13. Birthplace: New York

MOTHER
14. Maiden Name: MARY MANNING
15. Birthplace: Manchester, England

16 (a) Informant:
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Sepulcher Cem.
Location: New Rochelle, N.Y.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Filed by (Date) (b) [illegible] Registrar

SEP 6 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948 at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Sept 5 1948.
and that I last saw him alive on Sept. 5 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration: +10 yrs.

Due to: Hypertensive and Arteriosclerotic heart disease

~~Due to~~ disease

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature E. W. Smith
Address JOHNS HOPKINS HOSPITAL Date signed 9/5/48 M.D.

G66564 ✓ G66564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna M, Jones (Edna Muriel Jones)

3 (b) If veteran, name war: - no
3 (c) Social Security Account No.: - no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: William P. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	22	hr. min.

9. Birthplace Parsons, W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lloyd W. Warner
13. Birthplace W. Va.

MOTHER
14. Maiden Name Cora Carrico
15. Birthplace W. Va.

16 (a) Informant Mr. William P. Jones
(b) Address 2430 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1948 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Sept 3 1948. and that I last saw h[illegible] alive on Aug 25 1948.

Immediate cause of death	Duration
Carcinomatosis	
Due to Papillary Adenocarcinoma of ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Dec 1947
Major findings of operation Ca of ovary
Post-radiation Uremia
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E Gardner M. D.
Address 1211 Eutaw Pl Date signed 9/3/48

G66565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5506 South Bend Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5506 South Bend Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME HANNAH R. RUDDOCK

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Thomas Herbert Ruddock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 26, 1861

8. AGE: Years: 87 Months: 5 Days: 7 If less than one day: hr. min.

9. Birthplace: Gaithersburg, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: George Enoch Noyes

13. Birthplace: England

MOTHER

14. Maiden Name: Suzanna Davis

15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. William W. Werking

(b) Address: 5506 South Bend Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1948 (month) (day) (year)

(c) Cemetery or crematory

Location: Washington, D. C.

18 (a) Funeral director: Wm. J. TICKNER & SONS

(b) Address: North & Pa. Aves.

19 (a) (Date rec'd by registrar) [illegible] (Registrar)

(b) 6 Sept

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to 9/3 1948 and that I last saw h[illegible] alive on 9/3 1948.

Immediate cause of death: Coronary occlusion — Duration: 2-3 hrs

Due to

Due to Appendicitis

Other Conditions: Partial stenosis of left Pulmonary artery

(Include pregnancy within 3 months of death)

Date of operation: no

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [signature]

Address 3902 Kenesaw Ave. Date signed 9/4/48

G66566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8 3a

G66566
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 W. Hamburg
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhemena Lopez — Willie Lopez
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race Negro
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Archie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1867
8. AGE: Years 61 | Months | Days | If less than one day: hr. min.
9. Birthplace Ala. (Town, county, and state)
10. Usual Occupation Housemaker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Virgie Thomas
15. Birthplace Ala.

16 (a) Informant Archie Gilmore
(b) Address 635 Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Hamilton Ave

19 (a) (Date received by registrar) (b) [illegible]

SEP 8 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948, at 12 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1948, to 9-2 1948, and that I last saw her alive on 9-2 1948

Immediate cause of death Cerebral vascular accident

Due to Hypertension

Due to

Other Conditions Pontine Neuroglioma (PONTINE GLIOMA)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. E. Bradley Jr
Address Provident Hosp Date signed 9-2-48

Dr Hawkins

666567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666567

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424. w. Biddle. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424. w. Biddle. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William. H. Griggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. June. 18. 1910

8. AGE: Years 37 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Farmsvill, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Williams. Griggs
13. Birthplace Farmsvills. Va.

MOTHER 14. Maiden Name Gergania. Griggs
15. Birthplace Farmsvills. Va.

16 (a) Informant Mrs. Fannie. Watkins
(b) Address 425. N. Wolfe. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9. 1948 (month) (day) (year)
(c) Cemetery or crematory Green. Creek. Cem.
Location Cumberland, Co. Va.

18 (a) Funeral director Elroy. O. Wilson
(b) Address 1000. Brantly. Ave.

19 (a) Date filed by registrar SEP 6 - 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/ 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/ 1948 to 9/4/ 1948 and that I last saw him alive on 9/4/ 1948

Immediate cause of death: Lobar Pneumonia — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 460 W. Biddle St. Date signed 9/6/48

PRESS WHITE CRAYON, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC-KP-6802 Beckner 666568

666568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 157E

PRESS WHITE PENCIL WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson #4 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 E. Joppa Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth William Beckner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25, 1948

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Elmer Beckner
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elsie Kiplinger
15 Birthplace Balto.

16 (a) Informant Elmer Beckner
(b) Address 1915 E Joppa Rd.

17 (a) B. (Burial, cremation, or removal) (b) Date buried 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director J. F. McCaney
(b) Address 130 E. Fayette St. Baltimore, Md.

19 (a) SEP 6 1948 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1948, to Sept. 4 1948, and that I last saw h[illegible] alive on Sept. 4 1948.

Immediate cause of death Congenital Heart Disease — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Patent Ductus Arteriosus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Robert E. Lenson M.D.
Address Mercy Hospital Date signed 9/4/48

G66569

BALTIMORE CITY HEALTH DEPARTMENT Sauers

CERTIFICATE OF DEATH

G66569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 175 W. Cromwell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sauers Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 15-1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
68	8			

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Martin Sauers
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Md.

16 (a) Informant John Sauers Jr. Son
(b) Address 1823 Covington St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DEVINE, INC.
(b) Address 745 LIGHT ST

SEP 8 - 1948 (Date rec'd by registrar) Registrar

Sauers

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1948 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to 9/3 1948 and that I last saw him alive on 9/3 1948

Immediate cause of death	Duration
Uremia	
Due to Urinary Obstruction	
Due to Carcinoma of the Prostate	
Other Conditions Acute Alcoholism Hypostatic Pneumonia	

(Including pregnancy within 3 months of death)

Date of operation 8/25/48

Major findings of operation: Acute Appendicitis

of autopsy: Ca of Prostate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Franklin Sq. Hosp. Date signed 9/3/48

VS 150

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51 B

G66570
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 HAUBERT ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 HAUBERT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL EARNEST JUPITZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-6360

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNA MARIA (WILFE)
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) NOV 7, 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant MR FRED JUPITZ
(b) Address 1109 HAUBERT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 8 48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location PITCHIE HIGHWAY
18 (a) Funeral director JOHN E. PETERMAN
(b) Address 715 LIGHT ST. -30
19 SEP 6 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 4, 1948; at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from APR. 25, 1947 to SEPT. 4 1948. and that I last saw him alive on AUG. 27 1948.

Immediate cause of death Carcinoma of Prostate Gland with metastasis to Liver — Duration 1½ yrs
Due to
Due to
Other Conditions Arteriosclerotic hypertensive heart disease (Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: Inoperable
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James E. Peterman M. D.
Address 1226 Hanover St Date signed 9-4-48

VS 159

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 HANOVER ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 HANOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIETRICH H. N. ELLERMANN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNIE HEINLEIN
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr) JULY 1, 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
72				

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation FARMER
11. Industry or business

FATHER
12. Name FRANK ELLERMANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISE ELLERMANN
15. Birthplace ~~GERMANY~~

16 (a) Informant MRS ANNIE ELLERMANN
(b) Address 1601 HANOVER ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 7 48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN, MD

18 (a) Funeral director JOHN F. DENNELLY
(b) Address 715 LIGHT ST - 30

SEP 6 - 1948
(Date rec'd by registrar)

(a) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1948 at 3 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 2 1948 to Sept 3 1948, and that I last saw him alive on Sept 3 1948.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to	
Due to	
Other Conditions Hypertension. Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury —

23. Signature John G. Schwenk, M.D.
Address 1337 S Charles St Date signed 9/4/48

G66572 Cascio ✓ G66572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hosp. 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cascio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
86				

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Salvatore Cascio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Cascio
15. Birthplace Italy

16 (a) Informant J. R. Alberto
(b) Address 1707 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd
19-

18 (a) Funeral director Joseph Fusaro Inc
(b) Address 3 E Fremont Ave

19 [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948 at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept. 4 1948, and that I last saw him alive on Sept. 4 1948.

Immediate cause of death Myocardial Infarction — Duration

Due to Hypertensive Arteriosclerotic Cardiovascular Disease

Due to Coronary Sclerosis

Other Conditions Mesenteric Thrombosis, possible.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel S. Silverstein
Address West Balto Gen Hosp Date signed 9/7/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 66657 3

CERTIFICATE OF DEATH

Registered No. 8 3 a

G66573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard, Inter Sts
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Frederick
(c) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ESTELLA DEVILBISS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Maurice Devilbiss | 6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr) March 15th 1901

8. AGE: Years 47 | Months unknown | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

PARENTS

12. Name Harry Lowman
13. Birthplace Md.

MOTHER

14. Maiden Name Pearl Haines
15. Birthplace Md.

16 (a) Informant Maurice Devilbiss
(b) Address New Windsor Pa.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lingamore
Location Unionville, Fred. Co. Md.

18 (a) Funeral director C. M. Watts Winfield Md.
(b) Address

(c) Date rec'd by registrar SEP 5 - 1948 (b) Registrar for Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 8-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 4 1948 and that I last saw h a alive on Sept 4 1948

Immediate cause of death	Duration
cardio-respiratory failure	
Due to Cerebro-vascular accident	
Due to Malignant hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Jos Shea
Address Univ Hospital Date signed 9/5/48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G66574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66574 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME anthony Jajeczynska (Yazvick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Ukrainia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace Ukrainia

MOTHER
14. Maiden Name —
15. Birthplace Ukrainia

16 (a) Informant Jennette Venavage
(b) Address 1523 Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. B. Tialkowski
Address 2007 Eastern Ave

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1948 to Sept 2 1948, and that I last saw him alive on Sept 2 1948.

	Duration
Immediate cause of death Respiratory failure - Pulmonary edema;	
Due to Hypostatic Pneumonia	1 wk.
Due to	
Other Conditions Hemiplegia, Rt side - cerebral accident. Arteriosclerosis	3 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arvin Goldman M. D.
Address 206 [illegible] Date signed 9/4/48

VS 150

111c

G666575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G666575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1608 Cherry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 Cherry St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Irene Skrenchuk

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-5456

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wasil Skrenchuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Not known

8. AGE: Years: About 52 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russian (town, county, and state)

10. Usual Occupation: Helper Hotel

11. Industry or business

FATHER 12. Name: Mike ?

FATHER 13. Birthplace: Russian

MOTHER 14. Maiden Name: Not know

MOTHER 15. Birthplace: Russian

16 (a) Informant: Wasil Skrenchuk

(b) Address: 1608 Cherry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 6-48 (month) (day) (year)

(c) Cemetery or crematory: Holy Trinity Russian

Location: Baltimore Md

18 (a) Funeral director: John Greblinskas

(b) Address: 423 S. Paca St

19 (a) Filed: Sept 6 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 3 1948.

That I last saw her alive on Sept 3 1948.

Immediate cause of death: Carcinoma of the cervix with metastasis

Duration: 1½ years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Tilney R. Gehlert Jr M. D.

Address 4700 Pimlico Rd. Date signed Sept. 4 1948

VS 150

G66576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66576

Registered No. 1224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rockhall Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Teresa Poole

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 9-27-1877

8. AGE: Years: 70 | Months: 11 | Days: 9 | If less than one day: hr min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Asha Fogwell
13. Birthplace: Md

MOTHER
14. Maiden Name: Amanda Schaeffer
15. Birthplace: Md

16 (a) Informant: Hospital Records
(b) Address: — — — — — —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 8-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Bado. Md.

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Heights Ave

19 (a) Date rec'd by Registrar: SEP 8 1948 (b) Registrar: [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/48 19 at 11:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 19 to 9-5-48 and that I last saw her alive on 9-5-48 19

Immediate cause of death: Pulmonary Embolism.
Duration: 10 Min

Due to Post-operative Phlebothrombosis.

Due to

Other Conditions Ventral hernia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Carlton T. Hall M.D.
Address: St Agnes Hosp. Date signed 9/6/48

1002

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G66577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution: Maryland State Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Bryonne Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Green

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	M

6 (b) Name of husband or wife Geo. W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1869

8. AGE: Years	Months	Days	If less than one day
79	0	3	— hr. — min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name John Zapf
13. Birthplace Germany

MOTHER
14. Maiden Name Kathryn ?
15. Birthplace Germany

16 (a) Informant Geo. E. Green (son)
(b) Address Brookhaw - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director C. Funk
(b) Address 330 Harford Rd
Huntington Williams

9 (m) 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-48 19 at 11 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948 to 9-5 1948 and that I last saw h e r alive on 9-5 1948.

Immediate cause of death	Duration
Cardio - Respiratory failure	—
Due to Generalized Carcinomatosis	—
Due to Carcinoma of ovaries	—
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation 9-2-48
Major findings of operation: 9-2-48 Carcinomatosis generalized.
of autopsy Carcinomatosis generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature W. E. Brindle M. D.
Address Md. Sen. Hosp. Date signed 9-5-48

G66578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G66578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine C. Kernan (KERNAN)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	seperated

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16 1900

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	4	18		

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Charles C. Scherer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie E Bolst
15. Birthplace Balto Md.

16 (a) Informant Mrs. Carroll C. Gordon
(b) Address 5912 Audrey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director P. Kane
(b) Address 1304 Hartford Rd

19 (a) 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948, at 5 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Inhaling gas
Due to
Other Conditions Dependency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/7/48 at about 6 00 P.M.
(b) Where did injury occur? 1217 N. Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury: Gas inhalation from gas range in kitchen

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

Sept 6

G66579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G66579

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: University Hospital

(c) Hospital or institution: Lombard & Green Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hours

(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. ~~1676 Oakley St~~ 1681 Cliftview Ave (If in institution, give usual residence)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET R PIPINO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	

6 (b) Name of husband or wife Walter Pipino Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 28-1921

8. AGE: Years 27 | Months unknown | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name MILTON CANTWELL md.

13. Birthplace

MOTHER 14. Maiden Name Dorothy Elizabeth Reid md.

15. Birthplace

16 (a) Informant Walter Pipino Jr.

(b) Address ~~1676 Oakley St~~

17 (a) Burial (b) Date thereof 9-9-48 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director J Burke

(b) Address 3 East Maryland Ave

19 (a) Date received by Registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 4 1948, and that I last saw her alive on Sept 4 1948.

Duration

Immediate cause of death Pulmonary Embolus

Due to Cardiac failure

Due to Rheumatic carditis - Mitral disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: cardiac enlargement, mitral stenosis, pulmonary edema

or Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. S. Klein

Address University Hospital Date signed 9/9/48

X

Holland

G66580 CERTIFICATE CORRECTED 9-1-50

BALTIMORE CITY HEALTH DEPARTMENT

(G66580)

ES-119601

CERTIFICATE OF DEATH 130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo. 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 Frances St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sumner F. Bagwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col. (W)

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 31, 1876

8. AGE: Years 71 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer - Coast Guard

11. Industry or business

FATHER
12. Name Isaac Bagwell
13. Birthplace ? Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS - Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 163 Huntington Ave. Huntington, W. Va.

19 (a) Rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1948 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1948 to 9-3- 1948
and that I last saw him alive on 9-3 1948

Immediate cause of death
For advanced pulmonary tuberculosis with cavitation — Duration 10 mos.
Due to
Due to
Other Conditions Diabetes mellitus — 5 years
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hospitals Date signed 9-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G66581
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
Gmeral German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. Bockstie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1863

8. AGE: Years 85 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franz H. Bockstie
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Schuman
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz,
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location

18 (a) Funeral director Harry A. Bockstie
(b) Address 4101 Edmondson Ave.

19 (a) 9/6/48 (Date rec'd by registrar) (b) Evelyn M. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5/48. 19 12-noon. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1/48 19 to Sept 5/48. and that I last saw her alive on Sept. 1/48

Immediate cause of death	Duration
Broncho-Pneumonia	7 days
Due to	
Due to	
Unknown.	
Other Conditions Chronic Endocarditis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Waldschmidt M.D.
Address 933 Hanover St. Date signed Sept. 5/48

VS 150

107

G66582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G66582 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4710 Norwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4710 Norwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Waldschmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife Henry Waldschmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1889

8. AGE: Years	Months	Days	If less than one day
59	6	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Krausz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Schneider
15. Birthplace Balto. Md.

16 (a) Informant Dr. Henry Waldschmidt
(b) Address 4710 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Luitze
(b) Address 4101 Edmondson Ave.

19 (a) 9/4/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3/48. 19 7/48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1/48 to Sept. 3/48. and that I last saw her alive on Sept. 3/48.

Immediate cause of death: Gastro-Intestinal Adeno-Carcinoma. — Duration: 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Waldschmidt M.D.
Address 933 Hanover St. Date signed Sept. 5/48.

VS 150

1202 St Paul

666583

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666583 Registered No.

CERTIFICATE OF DEATH 124 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 6
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline E. Swein Carrie E. Swein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife Peter C. Swein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	26	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hartsel Center
13. Birthplace Ohio

MOTHER
14. Maiden Name Minnie ---------
15. Birthplace Ohio

16 (a) Informant Peter C. Swein
(b) Address 1924 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7/48 (month) (day) (year)
(c) Cemetery or crematory Lorriana Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry F. Leitzke.
(b) Address 4101 Edmondson Ave.

19 (a) 9/6/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1948 at 21 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1946 to 9/4 1948, and that I last saw him alive on 9/3 1948

Immediate cause of death: Coronary occlusion. — Duration 1 hr.
Due to Arteriosclerosis. — 5 yrs
Due to Hypertension — 5 yrs
Due to Cerebral Hemorrhage. — 2 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw Boom M. D.
Address 1202 St Paul St Date signed 9/7/48

VS 190

G66584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66584
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 Herring Court
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAZEL P. KENDRICK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry J. Kendrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1892

8. AGE: Years: 56 | Months: 0 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Moyer, Penna. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Benjamin W. Williams
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Elizabeth Holland
15. Birthplace: Penna.

16 (a) Informant: Mr. G. S. Kendrick
(b) Address: 8501 Chestnut Oak Rd. Towson, Md.

17 (a) Removal (Burial, cremation, or removal)
(b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Sylvan Heights
Location: Uniontown, Pa.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 5 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5, 1948 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1948, to Sept 5 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death: Cerebral Hemorrage — Duration: 9/5/48
Due to: Chr. Myocarditis — 1947
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul Brown M. D.
Address 1663 W. North Ave Date signed 9/6/48

VS 150

G8585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66585

Registered No. 84)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins and Catons Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Whiting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Dr Lewis B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1912

8. AGE: Years 36 | Months 5 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David B. Ford
13. Birthplace Maryland

MOTHER
14. Maiden Name Pearl A. Ahern
15. Birthplace Maryland

16 (a) Informant Mrs. Ford
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Funeral Mansion
(b) Address 1217 St. Paul Street

19 (a) SEP 7 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 8:30 PM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Heart Failure

Due to Auricular Fibrillation

Other Conditions Neurogenic Shock Hysteria.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McClellan M.D.
Medical Examiner.
Date signed 9-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G66586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666586

12B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1450 N. Carolina St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Carvel Road, Pasadena, Md. (If rural give location)
(e) Citizen of foreign country? No. Yes or (No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Petronella Ruby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carl Ruby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-23-12

8. AGE: Years 36 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Hswife

11. Industry or business

FATHER 12. Name Joseph Mitchell
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Dieter
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory London Pk. Cem
Location Frederick Ave.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 121 S. Paul St.

19 SEP 7 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 9-4 1948.
and that I last saw her alive on 9-4 1948.

Immediate cause of death Pulmonary arrest-

Duration

Due to Tuberculosis (Pulmonary)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify)
(e) Means of injury

23. Signature John Rabbitt, M.D. M.D.
Address St. Joseph Hosp. Date signed 9-4-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666587 (Baltimore)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Catonsville Ave
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Catonsville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fredrick Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Whiting II

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1930

8. AGE: Years	Months	Days	If less than one day
13	8		hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis B Whiting
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Catherine Ford
15. Birthplace md.

16 (a) Informant Dr Lewis B Whiting
(b) Address 319 Med Arts Bldg

17 (a) Burial (b) Date thereof 9/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto Co.

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul st

19 (a) SEP 7 - 1948 (b) Baltimore, Md.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5, 1948, at 4:15 A M

21. I certify that I took charge of the remains described above, held an Inquiction thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia and Shock

Due to 2nd° and 3rd° Burns 90% body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4-48 at 2:15 P.M.
(b) Where did injury occur? Near Catonsville Baltimore Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? On Farm While at work? No
(d) Means of injury Burns from Gasoline explosion.

23. Signature John B. McFarlen M.D.
Medical Examiner
Date signed 9-5-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

✓ 666588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4410 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry L. Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emily Stark Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17th 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	10	18		

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Real Estate

FATHER
12. Name Lewis N. Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Royston
15 Birthplace Md.

16 (a) Informant Miss Emily Bennett
(b) Address 4410 Roland Ave

17 (a) Burial (b) Date thereof 9/7/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 S. Paul St.

19 SEP 7 - 1948 (b) Hamilton Williamson
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 - 1948 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Sept 1948, and that I last saw h[illegible] alive on Sept 1948.

Immediate ~~cause~~ of death	Duration
(a) Coronary Occlusion	
Due to	
Due to	
Other Conditions Duodenal Ulcer	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury William J Belfield

23. Signature
Address 5216 Roland Ave Date signed Sept 8th 1948

~~correct age is especially important. Physicians: please write the causes of death clearly and legibly.~~

VS 150

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

666589 ✓ Registered No. 666589

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Gilbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Polyanski (Annie Polunsky)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Stanley Polunsky
(b) Address 1317 Filbert St

17 (a) Burial (Burial, cremation, or removal) **(b)** Date thereof Sept 7 -48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anundel County

18 (a) Funeral director Joseph Kasmakas Inc
(b) Address 602 Washington Blvd

19 SEP 7 - 1948 (Date rec'd by Registrar) **(b)** [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948, at 6 A M

21. I certify that death occurred on the date above stated that I attended deceased from 8/6 1948 to 9/7 1948 and that I last saw h[illegible] alive on 9/3 1948.

Immediate cause of death Cardiac failure.

	Duration
Due to	
Due to	
Other Conditions Arteriosclerosis. Malignancy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy Carcinoma of pancreas. Cirrhosis of liver.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Maryland Ave Date signed 9/7/48

VS 150

66590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G66590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Ginsberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh	married

6 (b) Name of husband or wife Samuel L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1877

8. AGE: Years	Months	Days	If less than one day
70 71	9	29	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Samuel L Ginsberg
(b) Address 4017 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 Filed SEP 7 1948 (Date received by Registrar) (b) [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1948, at 5:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 1948, to 9/6 1948, and that I last saw her alive on 9/6 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Diabetes Mellitus Old Cerebrovascular accident (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marjorie Oxman, M. D.
M. D.
Address Sinai Hosp. Baltimore Date signed 9/6/48

VS 150

107

66591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 66591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4825 Palmer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lerner (LERNER)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Meude
13. Birthplace Russia

MOTHER
14. Maiden Name Tobye
15. Birthplace Russia

16 (a) Informant Harry Lerner
(b) Address 4825 Palmer ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Perkins Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

SEP 7 - 1948 (b) [illegible]
(Date received by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/a /48 to 9/6/48, and that I last saw h[illegible] alive on 9/6 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Juanita B. Landau M. D.
Address Sinai Hospital Date signed 9/6/48

X

666592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 666592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pond—1100 Blk. Frankfirst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Smithson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Chisley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1934

8. AGE: Years 13 | Months 11 | Days 24 | If less than one day hr. 1 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

MOTHER | FATHER

12. Name James Chisley

13. Birthplace Md

14. Maiden Name Marie Carroll

15. Birthplace Md

16 (a) Informant: Mary Wilson

(b) Address 638 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George G. Kelson

(b) Address 1300 Pennsylvania Ave

19 (a) SEP 7 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident probably, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found: 9-3-48 at 1:45 P M.

(b) Where did injury occur? Found: Arundel Sand & Gravel Co 1100 Blk. Frankfirst Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work?

(d) Means of injury Found drowned

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 9/3/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

G66593
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Whatcoat Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Whatcoat Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE HENRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Leroy Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) month a 1899

8. AGE: Years: 49 | Months | Days: - | If less than one day: hr. min.

9. Birthplace: md (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: John Hackett
13. Birthplace: md

MOTHER
14. Maiden Name:
15. Birthplace: —

16 (a) Informant: Georgeanna Johnson
(b) Address 1053 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory not Calvary
Location md

18 (a) Funeral director George B. Nelson
(b) Address 1303 Pennsylvania Ave

SEP 7 - 1948 (Date rec'd by registrar)

(b) Funeral Director, Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 10:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uterus Retroflexion Infection

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryze M.D.
Medical Examiner
Date signed Sept 7 48

P

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66594

ES-113829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo. 26 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 China St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Boyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Feb. 3. 1927

8. AGE: Years	Months	Days	If less than one day
21	7	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willis Boyer
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Johnson
15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 N. Stricker St.

19 SEP 7 1948 (b) [illegible]
(Date rec'd by local registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-48 1948 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1947 to 9-4 1948 and that I last saw her alive on 9-4 1948

Immediate cause of death	Duration
Bilateral far advanced pulmonary Tuberculosis with Cavitation	14 months
Due to	
Due to	
Other Conditions Tuberculosis spleen, pleura, larynx & pericardium	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.

Address Baltimore City Hosp. Date signed 9-5-48.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

Registered No. G66595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E. Clement st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Clement st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Steencken

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-2447

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hermine Steencken

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 9-1876

8. AGE: Years 72 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tool Fitter

11. Industry or business Shipping Co.

FATHER
12. Name Frederick Steencken
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Lankenau
15. Birthplace Germany

16 (a) Informant Hermine Steencken
(b) Address 1602 E. Clement st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Mr & Mrs. John W. Cuteri Son
(b) Address 531 Edmondson Ave

19 SEP 7 1948 (Date rec'd by Local Registrar) (b) [redacted]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948, at 12 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Sept 5 1948, and that I last saw h alive on Sept 4 1948.

Immediate cause of death
Terminal coma
Bronchial Pneumonia — Duration 3d
Due to Acute leg ulceration — 1yr
Due to Chronic interstitial Nephritis — 1yr
INTERSTITIAL

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.F.A. Stevens M. D.
Address 2818 Harford Av Date signed 9-6-48

666596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 666596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ days) 2
(e) Length of stay in Baltimore (yrs., ~~mos.~~ ~~days~~) 91

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1906 Eastern Ave~~ 3004 Walker Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. ~~Shephard~~ Ismart

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, ~~widowed~~ or divorced. ~~Married~~

6 (b) Name of husband or wife Louise
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Sept 3 1857

8. AGE: Years 91 | Months 0 | Days 3 | If less than one day — hr. — min.

9. Birthplace Baltimore Maryland (Town, county and state)
10. Usual Occupation none Retired
11. Industry or business

FATHER 12. Name Louis ~~Ismart~~ Ismart
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name CATHERINE ~~Seager~~ SEAGER
15. Birthplace Md

16 (a) Informant Mrs. Charles Scherer
(b) Address ? ~~Baltimore~~ 3004 Walker Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof G-8-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director J. Frank
(b) Address 3307 Westwood Rd

19 SEP 7 - 1948 (Date rec'd by registrar) Huntington Maryland (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1948, at 8 31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1948 to 9-6 1948.
and that I last saw him alive on 9-5 1948.

Immediate cause of death: Respiratory failure — Duration: 1 day
Due to: Terminal bronchopneumonia — 4 days
Due to: Fracture, hip, ct. — 2 days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-4-48 at ? M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Elizabeth Nursing While at work? No (Specify type of place) Home
(e) Means of injury Fall - slipped on ball to floor

23. Signature W. Samuel A. Harris M.D.
Address Md. Genl. Hosp. Date signed 9/6/48

VS 150 To be approved by Med. Ex. For B.C.J. Tubinskie, by L. Thomas J. Maddis M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

Registered No. G66597

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1st Division 8S.

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)

(d) Street No. 726 Bradley St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Magdalia B. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-29-1900

8. AGE: Years 48 Months 8 Days 19 If less than one day hr. min.

9. Birthplace Cadiz Va (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace Va

14. Maiden Name unknown

15. Birthplace Va

16 (a) Informant Harry Matthews

(b) Address 726 Bradley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna Ave

19 (a) SEP 7 1948 (Date received by Local Registrar) (b) Filed by

vs 48

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/48 at 5:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1/48 to 9/4/48 and that I last saw h[illegible] alive on 9/4/48.

Immediate cause of death: Acute Myocardial Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/3/48

Major findings of operation: Fibromyomata uteri; Umbilical Hernia

of autopsy:

PHYSICIAN TA. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address Provident Hosp Date signed 9/4/48

666598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

666598 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2205 E. Biddle Street

(c) Hospital or institution:

(d) Length of stay in Hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2205 E. Biddle Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME John Thomas Schluttanhafer

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hannah Himmelheber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1880

8. AGE: Years	Months	Days	If less than one day
68	-	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired- Bethelehem Steel Co

11. Industry or business

FATHER 12. Name Henry C. Schluttanhafer

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary Birmingham

15. Birthplace Baltimore, Md.

16 (a) Informant Ruth Otradevec

(b) Address 717 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Schimunek Funeral Home Inc.

(b) Address 2601-03-05 E. Madison Street

19 (a) SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29th 1948 to Sept 4th 1948 and that I last saw h alive on Sept 4th 1948.

Immediate cause of death Heart Failure — Duration 24hrs

Due to Myocarditis — 1 year

Due to Arteriosclerosis — 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence , at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 9/7/48

VS 199

6599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 666599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N. Montford Ave #13 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Jung

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lillian M. Keller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1884

8. AGE: Years	Months	Days	If less than one day
64	3	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. S. Abell Co.

FATHER
12. Name John W. Jung
13. Birthplace Holland

MOTHER
14. Maiden Name Christina Wickman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian J. Batzer
(b) Address 216 Murdock Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 SEP 7 - 1948 (Date received by Registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948, at 5:50 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/3 1948, to 9/5 1948, and that I last saw him alive on 9/5 1948

Immediate cause of death	Duration
Cardio - respiratory failure	12 hours
Due to Cerebral hemorrhage	4 days
Due to Hypertensive C-V Disease	? years

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann
Address Maryland General Hosp. Date signed 9/5/48 (M. D.)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution: Anderson Convalescent Rest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Carlesen Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Samuel Ender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Edmund A. Ender

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1862

8. AGE: Years	Months	Days	If less than one day
86	2	9	hr. min.

9. Birthplace Burlington, Conn. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name [illegible] Samuel
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Edmund S. Ender
(b) Address 4506 Carlesen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location New Haven, Conn.

18 (a) Funeral director E. Willis Simonds
(b) Address 4510 Liberty Heights Ave.

19 Sept 7 - 1948 Huntington Maryland
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6" 1948 at 5:55 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 12 1947 to Sept 6 1948 and that I last saw her alive on Sept 3 1948.

Immediate cause of death	Duration
1) Primary Carcinoma of Colon	1 yr.
Due to	
Due to	
Other Conditions Cataract - Selerotic Heart Disease (Include pregnancy within 3 months of death)	- 5 yrs.

Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul F. Chambers M. D.
Address 4108 Liberty Hts Date signed 9/7/48

G66601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Monkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emory Nicholas Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/8/72
8. AGE: Years 75 | Months 10 | Days 28 | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name JAMES JOHNSON
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ANNIE WILLIAMS
15. Birthplace UNKNOWN

16 (a) Informant Patient
(b) Address MONKTON MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 9-48 (month) (day) (year)
(c) Cemetery or crematory UNION CHAPEL
Location MONKTON, MD

18 (a) Funeral director Howard S Hopkins
(b) Address Lutherville Md

19 SEP 7 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1948 at 5.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 9/6 1948, and that I last saw him alive on 9/6 1948.

Immediate cause of death: Hypostatic pneumonia — Duration 2 days
Due to Right sided hemiplegia
Due to Hypertensive arterio sclerotic cardiovascular disease
Other Conditions Gangrene of rt. foot.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Hyde M.D.
Address Provident Hosp Date signed 9/6/48

VS 150

666602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 666602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Ridgehill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C. INEMER, Sr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna M. Inemer

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): May 3, 1883

8. AGE: Years: 65 | Months: 4 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Chief Clerk

11. Industry or business: Balto. Police Dept.

FATHER
12. Name: Harry C. Inemer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Suzanna Brown
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Anna M. Inemer
(b) Address: 2120 Ridgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 6 1948, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 30 1948. to 9 - 6 1948. and that I last saw h[illegible] alive on 9 - 6 1948.

Immediate cause of death: Respiratory failure — Duration:

Due to: Bilateral Pneumonia

Due to:

Other Conditions: Cerebral Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: Frederick A. Strickler Jr. M. D.
Address: Bon Secours Hosp. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AVS 150

166603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 166603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1340 Presstman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Culley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 24 | 1897

8. AGE: Years 51 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Jas Henderson
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant Daisy Stepter
(b) Address 1340 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 | 9 | 48 (month) (day) (year)
(c) Cemetery or crematory Northumberland Co
Location Northumberland Co. Va

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Presstman St

19 [illegible] (b) Huntington, Virginia
(Signature of local registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-48 19 to 9-4-48 19, and that I last saw her alive on 9-4-48.

Immediate cause of death Resp. failure — Duration

Due to Brain abscess

Due to septicemia

Other Conditions Pyuria, arteriosclerosis, diabetes mellitus, Mitral
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. White
Address Hunt. Hosp. Date signed 9-4-48 M D

VS 150

Fee a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66604 GM. 122363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G66604 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9 Dys
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 S. Clinton St. Z 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Gaphardt

3 (b) If veteran, name war: none.
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Harry Gaphardt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27-1870

8. AGE: Years 78 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Christopher Moll (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Madeline ? (D)
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Edmondson Ave. & Fulton Ave.
18 (a) Funeral director Randall & Flegel
(b) Address 1800 W. Baltimore St.
19 SEP 7 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 3- 1948, at 9.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 24- 1948 to 9- 3- 1948, and that I last saw her alive on 9- 3- 1948.

Immediate cause of death Bronchopneumonia — Duration days

Due to

Due to 17 yrs

Other Conditions Cataracts, HCVD, CCPC, Nursing, diab. mellitus 4 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy Cataracts, HCVD CCPC, Lung & Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balto City Hosps Date signed 9/5/48

VS 150

G66605 BC-48-19478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 3-R
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Thames St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-1-48

8. AGE: Years	Months	Days	If less than one day
—	—	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Clifford Sadler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Helen Schmidt
15. Birthplace Baltimore Md

16 (a) Informant Father Sadler
(b) Address 1514 Thames St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Geo. A. Dudley
(b) Address Fulton Ave. & Fayette St.

19 9-7-48 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948 at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/5 1948 and that I last saw her alive on 9/5 1948

Immediate cause of death Resp. Failure — Duration 1 hr

Due to Pneumonia

Due to Atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. A. Fitzpatrick, M.D.
Address Mercy Hosp. Date signed 9/8/48

VS 150

Correct age is extremely important. Physician: please write the causes of death clearly and legibly.

G66606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66606 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Belmar Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Belmar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. McKewen

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret C.
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr) May 10 1861

8. AGE: Years 87 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Henry McKewen
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Byrne
15. Birthplace Scotland

16 (a) Informant Margaret C. Brackon
(b) Address 4220 Belmar Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Dippel Bros.
(b) Address 7110 Belair Rd.

19 (a) SEP 7 - 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to Sept. 5 1948 and that I last saw him alive on Aug. 28 1948.

Immediate cause of death	Duration
CEREBRAL THROMBOSIS	10 days
Due to CEREBRAL ARTERIO-SCLEROSIS	5 years.
Due to	
Other Conditions MYOCARDIAL DEGENERATION SENILITY 3 yrs.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 630 Belair Rd (6) Date signed 9/6/48

83B

Vs 150

G66607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927 ✓

Registered No. G66607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Barclay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAY M. WHITTLE

3 (b) If veteran, name war ##
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1870
8. AGE: Years 78 | Months | Days | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Athome
11. Industry or business

FATHER
12. Name T. Stockton Whittle
13. Birthplace Westminister, Md.

MOTHER
14. Maiden Name Berdelia O'Brian
15. Birthplace Ireland

16 (a) Informant Miss Francis Whittle
(b) Address 2526 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) SEP 7 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd 1948, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948 to Sept 2 1948, and that I last saw h alive on Sept-2 1948.

Immediate cause of death: Chronic Endocarditis — Duration: 3 months
Due to: Arterio Sclerosis — 1 year
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify place)
(e) Means of injury
23. Signature Hubert Wheeler M.D.
Address 1279 William St. Date signed 9/3/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WENZEL

G66608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66608 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hundred Block W. 37th St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 W. 37th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSHUA H. WENZEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Nellie Wenzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 31, 1871

8. AGE: Years 76 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Mail Clerk

11. Industry or business

FATHER
12. Name George Wenzel
13. Birthplace Unknown

MOTHER
14. Maiden Name Katherine Kibler
15. Birthplace Germany

16 (a) Informant Nellie V. Wenzel
(b) Address 822 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8, 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Paul E. Chenoweth Sr.
(b) Address 7615-17 Liberty Road

19 (a) [illegible] 17 - 1948 [illegible]
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 5 1948, and that I last saw him alive on Sept 5 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebro-vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Univ. Hospital Date signed 9/5/48

VS 150

666609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666609

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3433 Frederick Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3433 Frederick ave. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME George F. Rauch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie E.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	16	4 hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Charles F. Rauch

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Louise Kahn

MOTHER 15 Birthplace Germany

16 (a) Informant Mrs. George F. Rauch

(b) Address 3433 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director George A. Farley

(b) Address Fulton Ave & Fayette St.

19 (a) Date rec'd by (Registrar) SEP 7 1948 (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Sept 5 1948.

and that I last saw him alive on Sept 5 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Cardio Vascular Disease	
Due to	
Other Conditions Bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert Scarpati M. D.

Address 1724 W. Lombard Date signed Sept 17 '48

466610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 466610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2857 W LAFAYETTE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2857 W LAFAYETTE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H CROSS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife JULIA CROSS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL-10-1868

8. AGE: Years 80 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation RETIRED. CARPENTER

11. Industry or business —

FATHER
12. Name JAMES CROSS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace NOT KNOWN

16 (a) Informant JAMES CROSS
(b) Address 2857 W LAFAYETTE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Bernard C Hunter
(b) SEPT - 1948 E [illegible] Huntington [illegible]

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 6 1948, at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948, to Sept 6 1948, and that I last saw h[illegible] alive on Sept 3 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	
Due to Arterio sclerotic Cardiovascular disease with hypertension	Several years
Due to congestive failure	
Other Conditions Bronchitis (chronic)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury (Specify)

23. Signature Wm Michael M. D.
Address 2901 Edmondson Ave Date signed Sept 7 1948

VS 190

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66611

ES- 122722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

Registered No. G66611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 E. 21st. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) J
If yes, name country

3 (a) FULL NAME George Akers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife ? ~~Maria Akers (D)~~ MARIE AKERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1894

8. AGE: Years	Months	Days	If less than one day
54	6	17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ~~Maria Akers (D)~~ ?
15. Birthplace ?

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial-
(Burial, cremation, or removal)
(b) Date thereof 9-8-48
(month) (day) (year)

(c) Cemetery or crematory WOODLAWN.
Location MD

18 (a) Funeral director Bernard C. Harlan
(b) Address 121 E. West St.

19 (a) SEP 7 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1948 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1948 to 9-5-48 1948
and that I last saw him alive on 9-5- 1948

Immediate cause of death
Lobar pneumonia
? ~~carcinoma~~ ? tbc.
Duration 5 dys.

Due to Bronchogenic carcinoma c metastases to mediastinal nodes

Other Conditions Old coronary infarct. old tbc. Rt. hemiplegia old.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: CONSOLIDATION Consolidation RLL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M. D.
Address Balto City Hosp. Date signed 9-6-48

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Tab correct age is especially important.

666612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97 ✓ Registered No. 666612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) ~~Hospital or~~ institution: Home for the Aged Colored
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Melia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Minnie Goodwich
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 21, 1867

8. AGE: Years	Months	Days	If less than one day
81	5	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Richard Melia
13. Birthplace

MOTHER
14. Maiden Name Rose Dugan
15. Birthplace

16 (a) Informant ~~Sister~~ Sister / In Room
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winfield
(b) Address 900 East Fayette St

19 (a) SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 11: P.M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible], to [illegible] 2 1948.
and that I last saw him alive on Sept 4 1948.

Immediate cause of death	Duration
Edema Lungs	day
Due to [illegible]	hr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(e) Means of injury

23. Signature M. D.
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

✓ Registered No. G66613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Abbottson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Abbottson Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel T. Taylor

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose J. McCullough

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Oct. 27th., 1887

8. AGE: Years: 60 | Months: 10 | Days: 8 | If less than one day: ########## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Elevator Operator

11. Industry or business: Office Building

FATHER
12. Name: Charles Nicholas Taylor
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Laura Miles
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Rose J. Taylor--- Wife
(b) Address: 1537 Abbottson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Taylor Avenue, Balto. Co. Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Sept. 7 1948 Received by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5th., 1948, at 5/38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 9/5 1948.
and that I last saw him alive on 9/4 1948.

Immediate cause of death: Carcinoma of the Lung — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Joseph S. Stern M.D.
Address: 111 E. Lafayette St. Date signed 9/7/48

V S 150

Please write plainly, with CARBON INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66614 CERTIFICATE CORRECTED

HEALTH DEPARTMENT—CITY OF BALTIMORE G66614

83B

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Northway Apts- 3700 N Charles ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabel Pinkney (Mrs.) Bispham

(a) RESIDENCE NO. Northway Apts - 3700 N. Charles ST., 12-1 WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Newbold Bispham

6 DATE OF BIRTH (month, day, and year): July - 17 1874 (~~1875~~)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74 (~~73~~)	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Andrew Caldwell Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Maryland

12 MAIDEN NAME OF MOTHER: Sophia Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Miss Ethel R. Gray (sister)
(Address): Northway Apts. - City

15 Filed SEP 7 - 1948 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 5, 1948

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1948 to Sept. 5, 1948; that I last saw h[illegible] alive on Sept 5, 1948 and that death occurred, on the date stated above, at 10 45 p m.

The CAUSE OF DEATH was as follows:

Cerebral Thrombosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Truscheir M. D.

19 (Address) 1035 W. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burial-Arlington National Cemetery — DATE OF BURIAL: Sept. 8-1948

20 UNDERTAKER: Stewart + Mowen Company — ADDRESS: 108 W. North. City

66615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157 M

Registered No. 66615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn M. Zaworske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 19 - 1946

8. AGE: Years: 1 | Months: 10 | Days: 16 | If less than one day: hr. min.

9. Birthplace Balto. - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore F. Zaworski
13. Birthplace Balto. - Md.

MOTHER
14. Maiden Name Marie J. ~~Dechert~~ Duckett
15. Birthplace Balto. - Md.

16 (a) Informant Mario J. ~~Dechert~~ Zaworski
(b) Address 2715 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) Filed ... 19... (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1948 to 9/5 1948, and that I last saw h[illegible] alive on 9/5 1948.

Immediate cause of death	Duration
Heart failure	
Due to Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/1/48

Major findings of operation: Cong. dislocation hip

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature D. Schuchler

Address Bon Secours Hosp. Date signed 9/5/48 M.D.

VS 150

G66616
13-96267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

G66616
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Wilmer Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 19, 1888

8. AGE: Years	Months	Days	If less than one day hr.	min.
59	11	12		

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name John Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Brodley
15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) Date rec'd SEP 7 1948 (Registrar) (b) Filed (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 19 48 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 19 45 to 9-1 19 48
and that I last saw him alive on 9-1 19 48

Immediate cause of death: Cerebral Vascular Accident — Duration: 2 hrs
Due to: Hypertensive Cardiovascular Disease — 5 yrs
Due to:
Other Conditions: Bronchopneumonia, Lobar. — 3 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Nielsen Jr. M.D.
Address Balto City Hosp Date signed 7 Sept 48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G66617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EARL E. DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-16-7074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Daisy Davis

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1915

8. AGE: Years	Months	Days	If less than one day
33	7	0	hr. min.

9. Birthplace Halifax Co., Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business United American Metal Corp.

FATHER
12. Name Clem Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Barksdale
15. Birthplace Va

16 (a) Informant Daisy Davis
(b) Address 916 - 5th St. Lynchburg, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day)
(c) Cemetery or crematory Halifax
Location Halifax Co. Va

18 (a) Funeral director Charles R. Lawson
(b) Address 802 Madison Ave Lynchburg, Va

19 (a) SEP 7 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 9:55 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema
Due to Acute congestive cardiac failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-31-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66618

ES- 121119

108

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals. 3-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 28 days.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 233 Albermarle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Virginia Locke (Miss. Virginia Hill.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-26-6468

4. Sex: F.

5. Color or race: W

6 (a) Single, married, widowed, divorced: Sep.

6 (b) Name of husband or wife: Albert Locke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1930?

8. AGE: Years 18 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Chattanooga Tenn. (Town, county, and state)

10. Usual occupation: Telephone Operator

11. Kind of business/industry: Telephone

12. [illegible] Hill

13. [illegible] Tenn.

14. Maiden Name [illegible] H. Mahan

15. Birthplace Pittsburgh Georgia.

NOTES

16 (a) Informant Clyde F. Hill

(b) Address 233 S. Albemarle St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery.

Location North. & Milton.

18 (a) Funeral director Frank Kelly Koce

(b) Address 322 S. High St.

19 (a) Date received (Registrar) SEP 7 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1948 at 11:25 A M

I certify that death occurred on the date above stated; that I attended deceased from 7-9- 1943 to 9-6- 1948, and that I last saw her alive on 9-6- 1948.

Immediate cause of death: Lobar pneumonia, r lower lobe — Duration: 3 days.

Due to

Due to

Other Conditions Probable Hodgkins Disease — 1 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William A. Venkins

Address Balto City Hosp Date signed 6 Sept 48 M D

VS 150

BC-KP-18204

666619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 666619

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 West Hamburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy James (462395)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 4 hr. 35 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy James
13. Birthplace Georgia

MOTHER
14. Maiden Name Alline Robinson
15. Birthplace North Carolina

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 7 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1948, to August 23 1948, and that I last saw him alive on August 23, 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul O'Brien M. D.
Address The Johns Hopkins Hospital Date signed 8-26-48

G66620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66620

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Middle River
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Navigator Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Loudenmilch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	wdr.

6 (b) Name of husband or wife

6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) 10-13-1897

8. AGE: Years	Months	Days	If less than one day
50	10	25	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name John Loudenmilch
13. Birthplace

MOTHER 14. Maiden Name Edna Reynolds
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Harrisburg Pa.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19. SEP 8 - 1948 (Date rec'd by registrar) Mortician for Mr. Cook

VS 150

MEDICAL CERTIFICATION 10 A

20. DATE OF DEATH Sept. 7 1948, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1948 to 9-7- 1948 and that I last saw h[illegible] alive on 9-7- 1948

Immediate cause of death: Acute anterior myocardial infarction — Duration: 5 days

Due to Coronary Thrombosis

Due to Coronary arteriosclerosis

Other Conditions Dextrocardia Dextrocardiasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertram E. Sparkle

Address JOHNS HOPKINS HOSPITAL Date signed 9/7/48

66621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: RAYMOND S. ADDISON

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-2390

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1892

8. AGE: Years: about 54 | Months: 10 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housemaid

11. Industry or business: Belvedere Hotel

FATHER 12. Name: Frank D. Addison

13. Birthplace: Balto Md

MOTHER 14. Maiden Name: Isabella C. Cunningham

15. Birthplace: Balto. Md.

16 (a) Informant: T. S. Addison

(b) Address: 5515 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory: Balto

Location: " Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St.

SEP 8 - 1948 (Date rec'd by Registrar) (b) Washington Blvd

VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1948, at 6:35 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Frank Royer M.D. (Medical Examiner)

Date signed 9-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66622

52a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2647 Aisquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 N. Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A. Schuldt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Sophia Schuldt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 12th 1877

8. AGE: Years	Months	Days	If less than one day
70	9	25	hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Schuldt
13. Birthplace Denmark

MOTHER
14. Maiden Name Anna Fondoren
15. Birthplace Denmark

16 (a) Informant Henry Schuldt
(b) Address 2647 Aisquith St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 11A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948, to Sept 7 1948, and that I last saw h~~im~~ alive on Sept 7 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kent Fisher M. D.
Address 1633 N. Mad. St Date signed 9/7/48

X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

666623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 E. 21st St.
(c) Hospital or institution: 12 + 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Ada Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband William Bowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 1st 1869

8. AGE: Years	Months	Days	If less than one day
79	8	6	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Noah Lankford
13. Birthplace Md.

MOTHER
14. Maiden Name Anna B. Atmah
15. Birthplace Va.

16 (a) Informant Willie M. Rich
(b) Address 417 E. 21st St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 SEP 8 - 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 11:35 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1937 to Sept 7 1948 and that I last saw h[illegible] alive on Sept 7 1948.

Immediate cause of death: Cardiovascular renal disease — Duration

Due to

Due to

Other Conditions Carcinoma of rt breast
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J Singer

Address 504 E Monument Date signed 9-7-48 M. D.

VS 150

131a

G66624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2407 Reisterstown Rd.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL E. SNEIDER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-4359

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sedonia Sneider.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1887.

8. AGE: Years	Months	Days	If less than one day
61	6	18	hr. 16 min.

9. Birthplace Lithuania. (Town, county, and state)
10. Usual Occupation Merchant.
11. Industry or business

FATHER
12. Name David W. Sneider,
13. Birthplace Lithuania.

MOTHER
14. Maiden Name Bluma Silverman,
15. Birthplace Lithuania.

16 (a) Informant Mrs. Sedonia Sneider,
(b) Address 2407 Reisterstown Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 SEP 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from about 1941. Sept 7 1948 and that I last saw h[illegible] alive on Sept 7 1948.

Immediate cause of death Pulmonary Edema — Duration 1 day
Due to Carcinoma of Intestine (about 1 yr)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1947
Major findings of operation: Carcinoma of Intestine
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3503 Garrison Blvd Date signed

VS 150

666625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 York Rd
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Olivia Mary Mattes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John R. Mattes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	5 25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Silas B. Wells
13. Birthplace Virginia

MOTHER
14. Maiden Name Lula R. Badler
15. Birthplace Virginia

16 (a) Informant John R. Mattes
(b) Address 4606 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgadi Rd

18 (a) Funeral director John A. Moran
(b) Address 3050 E. Balt. St.

1948 SEP 8 (Date rec'd by Registrar) (by)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 1948, and that I last saw her alive on Sept 1-1948.

Immediate cause of death Leucopho-Bla-stomata (Carcinoma) of the lymph-glands — Duration 4 months

Due to

Due to

Other Conditions ① Severe anemia ② Loss of weight
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Morano M. D.
Address 4624 York Road Date signed Sept 9 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666626

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 501 E Chase St

(c) Hospital or institution: St Frances Convent

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 501 E. Chase St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sister Agnes Diamond O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1890

8. AGE: Years 57 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER

12. Name unknown

13. Birthplace

MOTHER

14. Maiden Name unknown

15. Birthplace

16 (a) Informant: Mother M. Teresa O.S.P.

(b) Address 501 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location

18 (a) Funeral director McDuff A. Elliott Dyt

(b) Address 1129 N. Caroline St.

SEP 8 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1948, at 7 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1st 1948, to Sept 6 1948, and that I last saw her alive on Sept 5 1948.

Immediate cause of death: Myocardial insufficiency — Pulmonary edema — Duration: 6 hrs

Due to: Cirrhosis Toxemia — 1 day — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 502 N. Calvert St Date signed Sept 8 1948 M. D.

VS 150

X

66627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54R

Registered No. 666627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 251
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Maisel Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth T. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Julius Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/21

8. AGE: Years	Months	Days	If less than one day
27	2	14	hr. min.

9. Birthplace Penna. (Town, county, and state) Penn.
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Orlando Morotte
13. Birthplace Italy

MOTHER
14. Maiden Name Albina Cherroni
15. Birthplace Italy

16 (a) Informant Julius Schneider
(b) Address 2409 Maisel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location A.A. Co. Md.

18 (a) Funeral director H. H. Wilson and Son
(b) Address 605 N Calvert St.

19 (Date rec'd by registrar) SEP 8 - 1948 Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 6 - 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 - 1948, to 9-6 - 1948, and that I last saw her alive on 9-4 - 1948.

Immediate cause of death	Duration
Acute cardio respiratory failure	
Due to Intra-ventricular hemorrhage & Increased intra-cranial pressure	
Due to Third ventricle tumor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-24-48

Major findings of operation: Increased intra cranial pressure, hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in each place)
(e) Means of injury

23. Signature C. D. Thomas Jr. M. D.
Address Mercy Hospital Date signed 9-7-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G66628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospitals 20-24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 EDMONDSON Ave.
(If rural, give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME WEISHAMPEL, J. HARRY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: IDA Litzau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 2, 1870

8. AGE: Years 78 | Months 0 | Days 03 | If less than one day: hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation PRINTER

11. Industry or business PRINTING.

FATHER
12. Name JOHN.
13. Birthplace OHIO

MOTHER
14. Maiden Name ADDISON MARY
15. Birthplace MARYLAND.

16 (a) Informant Mrs. Ida Weishampel
(b) Address 2519 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Cem.

18 (a) Funeral director Geo. L. Berger Jr.
(b) Address 1517 Hollins St

19 (a) SEP 8 - 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 10:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 14 1948 to Sept 5 1948 and that I last saw h[illegible] alive on 9/5/ 1948.

Immediate cause of death	Duration
Due to Carcinoma of Bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/25/48

Major findings of operation Carcinoma of bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase, M. D.
Address Church Home Date signed 9-7-48

Correct age is especially important. Physicians: please write causes of death clearly and legibly.

VS 153

G66629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 775 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18th 1906

8. AGE: Years 42 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Harry D. Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs William L. Davis
(b) Address 745 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C-V disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature C. F. Sulbrick M.D.
Medical Examiner.
Date signed 9/9/48

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. 666630

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1142 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Wilkens

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Mar 19th 1880

8. AGE: Years: 68 | Months: 5 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: House Work

11. Industry or business: at Home

FATHER
12. Name: Maurice Flynn
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret Dillon
15. Birthplace: Ireland

16 (a) Informant: Miss Celia M. Flynn
(b) Address: 1142 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory: St Peters Cem.
Location: 1300 Maryland Ave

18 (a) Funeral director: John J. Cowan & Son
(b) Address: 901-03 Hollins St

19 (a) SEP 8 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

25

20. DATE OF DEATH Sept 6th 1948. at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948. to Sept 6 1948. and that I last saw her alive on Sept 6 1948.

Immediate cause of death	Duration
Cardio Respiratory failure	minutes
Due to Toxemia	3 days
Due to Ruptured Diverticulum DIVERTICULUM	5 days
Other Conditions Hypertensive Cardio vascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tommasello

Address 900 N. Lombard St Date signed Sept 7 1948.

123

VS 150

66631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G66631
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3(a) FULL NAME Albert Joseph Mauser

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Connie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-30-1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	3	5		

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Daniel Mauser

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Haley

15 Birthplace Pa

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Geo. W. Grimes & Son

(b) Address 511 N. Eutaw St.

19 (Date received by registrar) SEP 8 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 10.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7-1948 to 9-7-1948 and that I last saw [illegible] alive on 9-7-1948.

Immediate cause of death Bronchopneumonia & Cardiac failure — Duration 2 days

Due to Carcinoma of Bladder — 2 yrs.

Due to METERNOSIGMOIDECTOMY, RT

Other Conditions Metersigmoidectomy, RT. — 2 mos.

(Include pregnancy within 3 months of death)

Date of operation 7-16-48

Major findings of operation: INOPERABLE growth

of autopsy: Ca in [illegible] bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Willard E. Brown M. D.

Address JOHNS HOPKINS HOSPITAL Date signed

VS 130

Type or print plainly in ink. If physicians, please write the causes of death clearly and legibly.

G66632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Gartner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1879

8. AGE: Years	Months	Days	If less than one day
69	5	23	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name H. H.
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15 Birthplace Russia

16 (a) Informant Benesch Gartner
(b) Address 3737 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Kolker Cong Cemetery
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N North Ave

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1948 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1948 to Sept 3 1948.
and that I last saw h alive on 9/3 1948.

Immediate cause of death: Acute coronary infarction — Duration

Due to Ch coronary sclerosis

Due to Ch myocardial degen

Other Conditions Ch asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify)
(e) Means of injury

23. Signature H. H. Hornstein
Address 2048 Eastdale Date signed 9/8/48 M D

X

G66633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. G66633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ritthland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 S. Spring Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Felicia Graboski

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-12-6497

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jesse Graboski
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan-2, 1901

8. AGE: Years	Months	Days	If less than one day
47	8	4	..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Binkoski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ? Ladginski
15. Birthplace Unknown

16 (a) Informant Mr. Jesse Graboski
(b) Address 347 Spring Court

17 (a) Burial (b) Date thereof 9-9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Holy Rosary
Location Baltimore Co. Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 SEP 8 - 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 - 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1948 to 9-6 - 1948, and that I last saw h alive on 9-6 - 1948.

Immediate cause of death Pyelonephritis — Duration

Due to

Due to

Other Conditions Bronchopneumonia
Pulmonary tuberculosis - inactive
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hospital Date signed 9-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

S.E. Harris 133a

66634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G66634
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 1886

8. AGE: Years 63 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Clarkson
(b) Address 4200 Carlsview Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 [illegible] Schroeder Ave

SEP 8 - 1948
(Date rec'd by registrar)

(Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1948 at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Sept 6 1948, and that I last saw h[illegible] alive on Sept 6 1948.

Immediate cause of death
(Enter only one cause per line for a, b, and c.)
a Cerebral Thrombosis
Due to Myocarditis
b Arteriosclerosis
Due to
c
Other Conditions
(Include pregnancy within 3 months of death)

Duration
a 2 mos.
b 2 yrs.
c unknown

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L Tomm
Address 4015 Edmondson Date signed 9/7/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 666635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Springdale Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME Esther Rosabelle Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frank L. Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1869

8. AGE: Years 79 | Months 6 | Days 26 | If less than one day: hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Joseph George Smith

13. Birthplace Bermuda

MOTHER 14. Maiden Name Elizabeth Harnett

15. Birthplace Bermuda

16 (a) Informant Frank L. Reed

(b) Address 4001 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) SEP 8 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 5 1948.
and that I last saw h[illegible] alive on Sept 4 1948.

Immediate cause of death: Sarcoma of Transverse Colon — Duration: 6 mo.

Due to

Due to

Other Conditions Diabetes — 10 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.

Address 612 N Howard St Date signed

666636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. 666636

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 North Caroline Street

(c) Hospital or institution: St. Josephs Hospital 27-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5413 Hillburn Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME George Arthur Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No. 16-09-8770

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Pearl Sharp Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-9-87

8. AGE: Years 59 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Calvert County, Maryland (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business Balto. Life Ins. Co.

FATHER 12. Name Cuumpton G. Bowen

13. Birthplace Maryland

MOTHER 14. Maiden Name Jennie Lee Cusick

15. Birthplace Maryland

16 (a) Informant Mrs. Pearl S. Bowen

(b) Address 5413 Hillburn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave.

18 (a) Funeral director Krause Funeral Home

(b) Address 1216 S. Charles St.

19 SEP 8 - 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 6 1948 and that I last saw him alive on Sept 6 1948

Immediate cause of death Ruptured aneurysm of abdominal aorta — Duration

Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ruptured aneurysm of aorta

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ray E. Pierson Jr. M.D.

Address St. Josephs Hospital Date signed Sept 6 1948

VS 150

666637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. 666637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Presstman St
(c) Hospital or institution: 15-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6-0 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Presstman St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Ashby

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife John Ashby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Juriah Lee
15. Birthplace Va.

16 (a) Informant Pauline Parker
(b) Address 1315 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/45 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va

18 (a) Funeral director Geo. B. Wilson
(b) Address 1303 Presstman St

19 Filed 9-8-45 (a) (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1942 to 9-5- 1945 and that I last saw h- alive on 9-4- 1945

Immediate cause of death: Cardio-renal-vascular disease — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page, M.D.
Address 1516 N. Mount St. Date signed 9-8-45

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 666638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 58 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 Spring Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank A. Hugel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Agness Ompteda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Linesman Helper
11. Industry or business Gas & Electric Co.

FATHER	12. Name	Not known	
	13. Birthplace	"	"
MOTHER	14. Maiden Name	"	"
	15. Birthplace	"	"

16 (a) Informant Mrs. Robert Schoppert
(b) Address 244 S. Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

SEP 8 - 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 1:20 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 6 1948 Sept 7 1948
and that I last saw h[illegible] alive on Sept 6 1948

Immediate cause of death: Myocardial Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Ray E. Rusow Jr.
Address St. Joseph's Hosp. Date signed 9/7/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

Please type or print plainly; please write the causes of death clearly and legibly.

666639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 S. Clinton Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME: GEORGE HIPPLER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. ?

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: NONE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-8-1889

8. AGE: Years 59 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business ?

FATHER
12. Name IGNATUIS M. HIPPLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET HARTMAN
15. Birthplace BALTIMORE

16 (a) Informant ANDREW J. HIPPLER BRO.
(b) Address 3400 WOODSTOCK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-9-1948 (month, day, year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST. 31

19 DATE RECEIVED BY REGISTRAR SEP 8 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1948, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] contributing [ ] cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-9-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1645

66640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 E. Baltimore St.-Victoria (If rural, give location) Hotel
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD PENNEY

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GLADYS F. PENNEY

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG. 14, 1890

8. AGE: Years 58 | Months - | Days 21 | If less than one day: hr. min

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation MERCHANT SEAMAN

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant: GLADYS F. PENNEY
(b) Address WILLIAMSVILLE, N.Y. R.F.D. #1

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 8 48 (month) (day) (year)

(c) Cemetery or crematory F.G. Miller & Son.
Location Candor, N.Y.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31. Md

19 SEP 8 - 1948 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948, at 12:05 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to self-inflicted wound of neck

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-48 at 11:30 A. M. ?
(b) Where did injury occur? 740 E. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
(d) Means of injury Sharp Instrument

23. Signature Earl L. Rose M.D.
Medical Examiner
Date signed 9-4-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

666641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10+
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Ensor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT BRUNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 35 | Months | Days | If less than one day: hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Selon

11. Industry or business

FATHER 12. Name William Brunson

13. Birthplace S. C.

MOTHER 14. Maiden Name Daisy Holt

15. Birthplace Halifax Va

16 (a) Informant Sallie Miller

(b) Address 214 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8, 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1710 Blankley Ave

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1948, at 1.45 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following.

(a) Date of injury 9-6-48 at approx. 1.00 p. M.

(b) Where did injury occur? Found in front of 148 East St.

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury sharp instrument

23. Signature Earl L Royer M.D. (Medical Examiner)

Date signed September 7, 1948

VS 151

Keep this space free for important information. Physicians: please write the causes of death clearly and legibly.

666642 B.P. 48-21222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600 V. 666642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
Bon Secours Hosp. Balto
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Greenfelder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/48

8. AGE: Years | Months | Days: 1 | If less than one day: 30 hr. 30 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Williams Greenfelder
13. Birthplace Balto Md

MOTHER
14. Maiden Name Norma Heckman
15. Birthplace Balto Md

16 (a) Informant Mrs. Wm Greenfelder
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 48 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem
Location Druid Park

18 (a) Funeral director L. Heckman & Son
(b) Address 6067 Harford Rd
SEP 8 - 1948 (Date rec'd by registrar) (b) Huntington [illegible]

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1948 to Sept 5 1948 and that I last saw h alive on Sept 5 1948

Immediate cause of death Respiratory failure — Duration

Due to Cerebral injury

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Bon Secours Hosp Date signed 9/5/48

X1

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, PEN AND UNFADING INK.

666643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4717 Fernhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4717 Fernhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Keigler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William H. Keigler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 23 1867

8. AGE: Years: 80 | Months: 9 | Days: 15 | If less than one day: 14 hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Charles W. Kerr
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Glaeser
15. Birthplace: Germany

16 (a) Informant: Dorothy M. Keigler
(b) Address: 4717 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 10 1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem
Location: Baltimore Md

18 (a) Funeral director: E. Fillis Laurorsan
(b) Address: 4510 Liberty Heights Ave

19 (a) SEP 8 - 1948 (Date received by registrar) (b) [redacted]

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946, to Sept 7 1948 and that I last saw h M alive on Sept 7 19

Immediate cause of death: Diabetes mellitus — Duration 2 yrs 3 mo

Due to: Arterio sclerosis — 5 yrs

Due to: Hypertension — 3 yrs

Other Conditions: Secondary anemia — 6 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Walter D Tabler M. D.
Address Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66647 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdown (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 3rd. Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE Phillip WEBER

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-20-2351

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Roberta (Lorenz) Weber

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1883
If less than one day / hr. min.

8. AGE: Years 65 | Months 0 | Days 10

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Westinghouse

FATHER
12. Name: William Weber
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Christina Beiler
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Roberta L. Weber - widow
(b) Address: 113 - 3rd. Ave. Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9 /48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

SEP 8 - 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1948, at 3.55 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed September 6, 1948

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G66645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66645

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 444 Fosseth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha A. Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband or wife Philip Kraft

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept 10th 1868

8. AGE: Years 79 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Zentz
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Elva Harden
(b) Address 2076 Druid Park Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Jr
(b) Address 1217 St. Paul St.

SEP 8 - 1948
(Date rec'd by registrar)

(b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1948 6:45 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1948 to Sept 6 1948 and that I last saw her alive on Sept 2 1948.

Immediate cause of death: Cardiac Failure — Duration unknown

Due to Chronic Bronchitis

Due to Emphysema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Palmer Harden M. D.
Address 4012 Edmondson Date signed 9/8/48

VS 150

X

G66646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G66646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. WASHINGTON ST (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME CATHARINE ROSENTHAL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ROBERT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-1916

8. AGE: Years 32 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name JOSEPH WINGDIG
13. Birthplace Md.

MOTHER
14. Maiden Name ELLA PONTY
15 Birthplace Md.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Wm. Cook Inc
(b) Address 1213 St. Paul St. Huntington Williams, Md.

SEP 8 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948 to Sept. 7 1948, and that I last saw her alive on Sept. 7 1948.

Immediate cause of death Fracture, base skull. Left Hem. or Haem. intracranial

Due to Fall from 2nd story

Due to of house.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 9-7-48

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-7-48 at 2:00 P.M.
(c) Where did injury occur? Balt. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify)
(e) Means of injury Fall from window, lost balance, was standing on chair
23. Signature Lowell S. Rusitzky
Address Johns Hopkins Hosp. Date signed 9-7-48

VS 150 Medical Examiner Cert - Released to Hospital M.D.

066647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144c

066647

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Orleans St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eleanora Brooks

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 220-14-7206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Robert -
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 14, 1912.

8. AGE: Years	Months	Days	If less than one day
36	3	21	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Edward Cornish
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Helen Hoin
15. Birthplace Cambridge Md

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert L Williams
(b) Address 1515 McElderry St

19 (a) 9/4/48 (Date rec'd by registrar) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1948 to Sept 5 1948 and that I last saw him alive on Sept 5 1948

Immediate cause of death Aspiration of blood & vomitus, associated with hemorrhagic phenomenon

Due to Hypoprothrombinemia

Due to Hepatitis

Other Conditions Pregnancy, term, undelivered. Extradural hemorrhage
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Hepatitis, extradural hemorrhage

Duration
.....
.....
.....
.....
.....
.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Gilbert J. Valbuena M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

To be approved by the Med & Chirurg Faculty [illegible], M.D.

G66648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G66648

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2792 W. North Ave
(c) Hospital or institution:
15 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2792 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Francis Caple

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-6177

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sallie F. Caple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28th, 1862

8. AGE: Years 86 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace Finksburg, Carroll Co Md.
(Town, county, and state)

10. Usual Occupation Contractor (Retired)

11. Industry or business

FATHER
12. Name Joseph C. Caple
13. Birthplace Carroll Co., Md

MOTHER
14. Maiden Name Rebecca Shilling
15. Birthplace Carroll Co. Md.

16 (a) Informant Miss Mae Caple
(b) Address 2792 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Buchanan & Gore
(b) Address 2224 N. Charles St

19 (a) 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep't 7th, 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Sept 7 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death: a Arteriosclerosis — Duration: 10 Yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address Date signed 9/8/48

VS 150

Please fill in all items, with ink or typewriter. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Poppleton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY TAYLOR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Elizabeth Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1, 1893.

8. AGE: Years	Months	Days	If less than one day
54	11	5	hr. min.

9. Birthplace Huntington W. Virginia
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Taylor.
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Edith Thompson
(b) Address 22 N. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1948
(month, day, year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mr. Katie D. Williams
(b) Address 222 N. Poppleton St.
Baltimore, Md.

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 9-[illegible]-48

VS 151

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

666650

GM. 115723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666650 Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. High ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Bertha Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George Buck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1930

8. AGE: Years 18 Months 3 Days 24 If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Brown Jackson (Step Father)
13. Birthplace MD.

MOTHER
14. Maiden Name Emily Ryan
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie B. Williams
(b) Address 322 Schroeder Sts.
18 (c) 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 6- 1948 at 9.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 12- 6- 1947 to 9- 6- 1948, and that I last saw her alive on 9- 6- 1948

Immediate cause of death For advanced Pulmonary Tuberculosis with cavitation — Duration 3½ yrs.

Due to

Due to

Other Conditions Tuberculous Laryngitis. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Moran M. D.
Address Baltimore City Hosp. Date signed 9-7-48

VS 150

Copy or tape is especially important. Physicians please write the causes of death clearly and legibly.

666651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 307

666651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 W. Mulberry St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gray
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Nannie Gray
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) May 1894
8. AGE: Years 54 Months 4 Days If less than one day hr. min.
9. Birthplace Greenville S. C.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business
FATHER 12. Name Willis Gray
13. Birthplace Greenville S.C.
MOTHER 14. Maiden Name Ward
15. Birthplace Greenville S.C.
16 (a) Informant Rachel Bogden
(b) Address 307 Myrtle Ave.
17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Mrs Katie P. Williams
(b) Address 3226 Schroeder St
19 (a) 1948 (Registered by registrar) Washington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948, at 12 00 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to 9/5 1948, and that I last saw him alive on 8/30 1948.

Immediate cause of death Hemorrhage — Duration 4 mos.
Due to Ruptured Aortic Aneurysm
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury
23. Signature J. Curtis Stuart
Address 601 N. Carroll St Date signed 9/8/48

VS 150

G66652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G66652 Registered No. 156 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Md. University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Havre De Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. STAR Route Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Leroy Durbin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1945

8. AGE: Years	Months	Days	If less than one day
3	—	30	— hr. — min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. A. Durbin
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Mary Coopsell
15. Birthplace Md.

16 (a) Informant Mrs. Annie Mary Durbin
(b) Address Havre de Grace, Md. Star Route

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Havre de Grace Md.

18 (a) Funeral director F. Madison Mitchell
(b) Address Havre de Grace, Md.

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948 to Sept 8, 1948, and that I last saw him alive on Sept 8, 1948

Immediate cause of death Respiratory failure — Duration 48 hours

Due to Hyperpyrexia with convulsions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify)
(e) Means of injury

23. Signature William J. Holloway M.D.
Address University Hospital Baltimore, Md. Date signed 9-8-48

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

666653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Clinton St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Charles Arnold Moser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth H. Moser (nee Heim)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-91

8. AGE: Years 56 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired - Baltimore Transit

11. Industry or business

FATHER 12. Name Charles Moser
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Pauline Schlaak
15 Birthplace Germany

16 (a) Informant Mrs. Elizabeth Heim Moser
(b) Address 2228 E. Jefferson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1948 to 9-5 1948, and that I last saw him alive on 9-5 1948.

Immediate cause of death Pulmonary Congestion — Duration

Due to Arteriosclerotic Heart Disease - Left Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John Rehfuss, M.D. M. D.
Address St. Joseph's Date signed 9-5-48

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666654

666654 — 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State WEST VIR. (b) County
(c) City or town RANSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY GRAPES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-28-1948

8. AGE: Years	Months	Days	If less than one day
—	—	10	hr. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER
12. Name WALDO GRAPES
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name JUNE H. MERCER
15. Birthplace WEST VIRGINIA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Edgehill Cemetery
Location Charlestown W. Va.

18 (a) Funeral director Wm. J. Tiekner & Sons
(b) Address No. & Pa. Aves. Balt. 17, Md

19 (a) 1948 (Date rec'd by reg.) Registrar

EP 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 7 1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to 9-7 1948.
and that I last saw him alive on 9-7 1948.

Immediate cause of death Pneumonia — Duration

Due to Post-operative Tracheo-esophageal fistula & esophageal atresia.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9/2/48
Major findings of operation: Esophageal atresia
of autopsy: Pneumonia, mucosal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Markowitz M.D.
Address Johns Hopkins Date signed 9/8/48

66655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs. or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County St. Marys
(c) City or town Mechanicsville (If outside city or town limits, write RURAL and give town)
(d) Street No. rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR VERNON KURTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Madeline Kurtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-95

8. AGE: Years	Months	Days	If less than one day
53	9	26	25 hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Albert Leon Kurtz
13. Birthplace Illinois

MOTHER
14. Maiden Name Gertrude Obermann
15 Birthplace Ohio

16 (a) Informant Wife
(b) Address Rural

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va.

18 (a) Funeral director W. C. Keatinge Sons
(b) Address Leonardtown, Md

19 SEP (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1948 at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-1948, to 9-8-1948, and that I last saw him alive on 9-8 1948.

Immediate cause of death	Duration
Myocardial failure, acute	
Due to Myocardial infarction	5 days
Due to Coronary atherosclerosis	

Other Conditions Hypertension, Pulmonary edema, Congestion, Cirrhosis, liver
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Kurtz, M.D.
Address Mercy Hospital Date signed 9-8-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666656 48-116782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 666656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude David Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 18-1947

8. AGE: Years 10 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Glenn
13. Birthplace S.C.

MOTHER
14. Maiden Name Geraldine Carty
15. Birthplace Norwich, Conn

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 31 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 31 1948 (Date rec'd by Registrar) (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25- 1948 at 5.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21- 1948 to 8-25- 1948 and that I last saw him alive on 8-25- 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Cytoarchitectus	9 months
Due to Subdural hematoma	2 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2- Feb 1948

Major findings of operation: Subdural Hematoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Innes M. D.
Address Balt Date signed Aug 31, 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66657

BC-48-19007 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs. 6 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs. 6 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 S. Ogiole, Md.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Charles Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-48

8. AGE: Years	Months	Days	If less than one day
			10 hr. 6 min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER | FATHER

12. Name Louis Scott

13. Birthplace Baltimore Maryland.

14. Maiden Name Dologes Cagdarelli

15. Birthplace Baltimore Maryland.

16 (a) Informant Mrs. Dologes Scott

(b) Address 434 S. Ogiole Baltimore.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location [illegible] AUG 27 1948

18 (a) Funeral director [illegible] Commissioner of Health

(b) Address

19 (a) 8-24-1948 (Date received by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 7 40 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-21 1948 to 8-22 1948, and that I last saw him alive on 8-21 1948.

Immediate cause of death	Duration
Anoxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 842 E. Eutaw Date signed 8-24-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66658

66658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cold Spring Cemetery
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert P Holbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced.~~

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1879

8. AGE: Years 69 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Balto Transit

11. Industry or business

FATHER
12. Name Samuel Holbert
13. Birthplace Md

MOTHER
14. Maiden Name Sarah —
15. Birthplace Md

16 (a) Informant Jeneva Holbert
(b) Address 1226 W 36 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 48 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Greenmount Ave

18 (a) Funeral director Edmund Foulger
(b) Address 2359 Wash Blvd

19 SEP 9 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Sept 8 1948 and that I last saw h~~im~~ alive on Sept 7 1948

Immediate cause of death
1. Generalized Arteriosclerosis
2. Arteriosclerotic Heart Disease

Duration 10 yrs 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klemm M. D.
Address 3813 Edmondson Ave Date signed 9/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hospital Disposal Religion

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666659

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)

(d) Street No. 7204 Usted Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Gil (B) Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/2/48

8. AGE: Years | Months | Days: 1 | If less than one day: 31 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Small

FATHER 13. Birthplace

MOTHER 14. Maiden Name Kathryn

MOTHER 15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Hope

18 (a) Funeral director

(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar) (b) Huntington Valley, Md. Registrar

MEDICAL CERTIFICATION 25-A

20. DATE OF DEATH Sept. 3 1948, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw h alive on 19 .

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. E. Hopkins M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9-4-48

VS 150

666660

666660 U.M. Hospital Telegram

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

nursery Disposal

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenn Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Usted Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "a" Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-2-48

8. AGE: Years	Months	Days	If less than one day
		1	6 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Small
13. Birthplace ?

MOTHER
14. Maiden Name Kathryn ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 SEP 9 - 1948 Huntington Williamsport, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1948, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to 9-3 1948, and that I last saw her alive on 9-3 1948.

Immediate cause of death
Prematurity
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. B. Appleton M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 9-4-48

VS 150

Type or write with pen and ink; use black ink. Physicians: please write the causes of death clearly and legibly.

666661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 666661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5146 Stafford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beatrice B. Phillips

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife David S. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	4	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Brown
13. Birthplace England

MOTHER
14. Maiden Name Emma ?
15. Birthplace Ireland

16 (a) Informant Mr. David S. Phillips
(b) Address 5146 Stafford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address SEP 9 1948 Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 7.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Sept 8 1948, and that I last saw her alive on Sept 7 1948.

Immediate cause of death	Duration
Myocardial failure, acute	
Due to ventricular fibrillation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug. 27, '48
Major findings of operation: Fibroids uterus chronic cervicitis & cervical ca.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred K. McClintock Jr. M. D.
Address Community Hosp. Date signed 9/8/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

166662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. 166662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R. HANCOCK, Sr.

3 (b) If veteran, name war: World War #II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife: Amelia E. Trainor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 4, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	4	hr. min.

9. Birthplace: St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation: Credit Manager
11. Industry or business: Sandlers Dept. Store

FATHER
12. Name: Thos. J. Hancock
13. Birthplace: St. Mary Co., Md.

MOTHER
14. Maiden Name: Martha E. Robinson
15. Birthplace: St. Mary Co., Md.

16 (a) Informant: Mr. James R. Hancock, Jr.
(b) Address: 327 Upland Rd., Pikesville, 8, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: 1918 Baltimore, Md.

19 (a) Sep 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 11:30 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Brain wound of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at M.
(b) Where did injury occur? 3545 Chestnut Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Firearms

23. Signature Howard J. Masters M.D. Medical Examiner.
Date signed 9-8-48

VS 151

666663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

666663 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 Bosworth Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Bosworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: AUGUSTA C. PFEIL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 9, 1859

8. AGE: Years 89 | Months 1 | Days 29 | If less than one day: hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER 12. Name: August Pfeil

13. Birthplace: Germany

MOTHER 14. Maiden Name: Catherine Heinzerling

15. Birthplace: Germany

16 (a) Informant: Mrs. Emma H. Orr, niece

(b) Address: 5203 Bosworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1948 at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1948 to Sept 8 1948, and that I last saw her alive on Sept 8 1948

Immediate cause of death: Cerebral Vascular accident

Due to

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 14 Days

Date of operation: —

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Hearn M.D.

Address 3700 Eastern Ave. Date signed 9/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N. Patterson Pk. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Baker (Conway)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Charles Baker
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) Feb. 14 - 1887

8. AGE: Years 61 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business —

FATHER
12. Name Ignatius Yoss
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Myers.
15. Birthplace Balto. Md.

16 (a) Informant Frank Hill Jones
(b) Address 24 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 48 (month) (day) (year)
(c) Cemetery or crematory Laurel Heights
Location Deepwood Hill Rd.

18 (a) Funeral director John D. Connelly.
(b) Address 1801 Eastern Ave. Balto.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 3 30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 27 1944 to Sept 7 1948 and that I last saw h alive on Sept 7 1948.

Immediate cause of death	Duration
Coronal Thrombosis	4 yrs
Hypertension	
Due to Arteriosclerosis	1944
Kidney Condition	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature U. J. Calcina M. D.
Address 3426 Bank St. Date signed 7/7/48

VS, 150

666665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. 666665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 North Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMIL [illegible]NBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Salon SEP 1 1948

18 (a) Funeral director [illegible]

(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, 8.45p.M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, feel that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X] homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:

(a) Date of injury 8-17-48 at approx. 8.00PM.

(b) Where did injury occur? 1918 N. Rose St.

(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work) no

(d) Means of injury Hanged self by rope from banister

23. Signature [illegible] M.D. Medical Examiner

Date signed August 18, 1948

Please answer all questions, especially important. Physicians: please write the causes of death clearly and legibly.

66666 BC-48-1723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. (1) 66666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Fremont (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorraine Frances Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (c) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8 6 48

8. AGE: Years | Months | Days 1 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation New Born

11. Industry or business

FATHER
12. Name Leroy Jones
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Frances Martin
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Frances Martin
(b) Address 507 Fremont St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/ 1948 at 4:55 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20/ 1948 and that I last saw h alive on 8/20/ 1948

Immediate cause of death Respiratory Failure

Due to Resp. Distress

Due to Pneumonia Prematurity

Other Conditions Wgt. 7 lbs. 13 oz.
(Include pregnancy within three months of death)

Date of operation Not

Major findings of operation: None

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Bradbury

Address Provident Hosp. Date signed 8/20/48

VS 150

666667 48-18340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 666667

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carolann Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Albert Price
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mildred Elizabeth Metzger
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

SEP 9 - 1948 (Date rec'd by Registrar) (b)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 10:17 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/48 to 8/29 1948 and that I last saw her alive on 8/29 1948

Immediate cause of death: Cardiorespiratory failure — Duration 48 hrs.

Due to Partial atelectasis of new born.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. B. Jones Jr.
Address Maryland General Hosp. Balto. Md. Date signed 9/1/48

666668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 666668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Savage St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEO PAPLINSKI (PEPLINSKI) (djm)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Josephine Paplinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Nanticoke, Pa. (Town, county, and state)

10. Usual Occupation Maintenance Dept.

11. Industry or business Eastern Stainless Steel

MOTHER / FATHER

12. Name Michael Paplinski

13. Birthplace Germany

14. Maiden Name Mary Baudurski

15. Birthplace Northumberland, Pa.

16 (a) Informant D. A. Drapiewski & Son
(b) Address 22 W. Green St., Nanticoke, Pa.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory St. Francis
Location Nanticoke, Pa.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1948, at 2.20p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic stenosis

Chronic vegetations; chronic valvulitis

Hypertrophy of the heart; Edema and

~~Due to~~ congestion of the lungs; Moderate

arteriosclerosis including coronary arteries.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haddis M.D. (Medical Examiner)
Date signed September 9, 1948

VS 181

G66669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

Registered No. G66669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city limits, write RURAL and give town) Baltimore,
(d) Street No. 301 Willow Avenue (If rural give location) 531

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles RAZGAITIS

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 38 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Cable Sealer
11. Industry or business

FATHER
12. Name: George Razgaitis
13. Birthplace: Lith.

MOTHER
14. Maiden Name: Pauline
15. Birthplace: Lith

16 (a) Informant: Pauline Razgaitis
(b) Address: 531 Willow ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-48 (Month) (Day) (Year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Belair Rd.

18 (a) Funeral director: Joseph Nasiakos
(b) Address: 602 Washington Blvd

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1948, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Amputation right arm
Fractured ribs.
~~Due to~~ Fractured right ankle.
Infacts of Kidneys.
~~Other Conditions~~ Edema of lungs.
Anasarca.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-30-48 at ? M.
(b) Where did injury occur? Western Electric Co. Point Breeze, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Large spool of steel wire fell on him

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 9/7/48

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66670
461237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66670
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Madison, Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Douglas.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mamie Douglas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-19-72
8. AGE: Years 76 | Months 6 | Days 16 | If less than one day hr. min.
9. Birthplace Ill (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Arnold Douglas
13. Birthplace Tenn.

MOTHER
14. Maiden Name Henrietta Samuels
15. Birthplace S. C.

16 (a) Informant: records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10 1948 (month) (day) (year)
(c) Cemetery or crematory Lebanon Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Rev. George A. Holland
(b) Address 631 Druid Hill Ave.

19 (a) 1948 (Date rec'd by registrar) (Signature of registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948 at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26- 1948 to 9-5- 1948 and that I last saw him alive on 9-5- 1948.

	Duration
Immediate cause of death: Cardiac failure	12 hrs.
Due to: Hypertensive C.V. disease & cerebral accident	2-3 yrs. 18 mos.
Due to:	
Other Conditions: Carcinoma of prostate & metastases, inoperable	1 1/2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma of prostate
of autopsy: None

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard E. Goodwin M. D.
Address JOHNS HOPKINS HOSPITAL
Date signed 9-6-48

VS 150

666671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 666671

Please write clearly and legibly. Use ink. Do not use pencil. Do not fold this certificate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 W. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lobe Schneider

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Lillian T. Schneider

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr): Jan 5, 1886

8. AGE: Years 62 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Interior Renavator

11. Industry or business: Self

FATHER
12. Name: Lobe Schneider
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Christin ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. Lillian Schneider
(b) Address: 2804 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 (a) Sep 9 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 th. 1948 at 1.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1948 to Sept 8 1948 and that I last saw him alive on Sept 8 1948.

Immediate cause of death: Myocardial insufficiency — Duration: 1 week

Due to: Generalized carcinomatosis — Duration: 10 months

Due to: Carcinoma of the esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: March 1st 1948

Major findings of operation: Carcinoma of esophagus.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: W. Mitchell M. D.
Address: 2901 Edmondson Ave Date signed: Sept 9 1948

VS 150

666672 DC-48-880 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666672

CERTIFICATE OF DEATH 160a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: Univ. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Woodview Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Simmons A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name James W. Simmons
13. Birthplace ? S.C.

MOTHER
14. Maiden Name Sallie Lomax
15. Birthplace Greenville S.C.

16 (a) Informant Mother
(b) Address Same

17 (a) Gift Disposal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1948, at 12 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948 to Aug 25 1948, and that I last saw him alive on 8-25 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Intra-cranial Hemorrhage

Due to Pre-maturity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Smedley Jr. M. D.
Address Univ. Hosp. Balt. Date signed 8-25-48

VS 150

X

666673 C-48-181 ✓ 666673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Taylor, Baby Boy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 20, '48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Clarence Taylor

13. Birthplace

MOTHER 14. Maiden Name Beatrice

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1948, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 26 1948 and that I last saw him alive on Aug 26 1948.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, or industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred R. McDaniel Jr. M. D.

Address University Hosp. Date signed Aug

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66674 BC = 48-1856 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66674 ✓ 107

Registered No.

1. PLACE OF DEATH:
(c) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp., 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 McKean Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years | Months | Days | If less than one day 14 hr. min

9. Birthplace Univ. Hosp., Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Williams
13. Birthplace N.C.

MOTHER 14. Maiden Name Naomi Williams
15. Birthplace N.C.

16. (a) Informant Same as 14
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) Sept 9 1948 Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/48 at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 27 1948 to 8 28 48
and that I last saw h/ alive on 8 25 19 48

Immediate cause of death Asphyxia.

Due to Aspiration Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Clinic Hosp Date signed 9/9/48

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666675 BC-48-1908 S

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. 666675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balt. Gen. Hosp.
(c) Hospital or institution: 24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hr 20min. 1822 Balt St
(e) Length of stay in Baltimore (yrs., mos., or days) 15hr 20min If yes, name country

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. So. Balt. Gen. Hosp. (If rural, give R.F.D. number)
(e) Citizen of foreign country? (Yes or No)

3 (a) FULL NAME Son of Clarence & Geraldine Neal - 13

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/48

8. AGE: Years | Months | Days | If less than one day 15 hr. 20 min.

9. Birthplace So. Balt. Gen. Hosp. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Clarence
13. Birthplace Baltimore

MOTHER 14. Maiden Name Geraldine Blose
15. Birthplace Baltimore

16 (a) Informant Geraldine Neal
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore Federal Street SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6/48 1948 at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1948 to 9/6 1948, and that I last saw him alive on 9/6 1948.

Immediate cause of death Atelectasis — Duration 15 hr. 20 min.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 9-6-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666676 BC-48-1057 ✓ 666676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18 + 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city limits, give township or R.F.D. number)
(d) Street No. 503 Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-48

8. AGE: Years | Months | Days: 2 1 | If less than one day: hr. min.

9. Birthplace University Hospital (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Williams
13. Birthplace Windsor N. C.

MOTHER 14. Maiden Name Eugenia Simons
15. Birthplace Colerain N. C.

16 (a) Informant Mr Rosebold Md
(b) Address University Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] SEP 8 1948

18 (a) Funeral director [illegible] Commissioner of Health
(b) Address

19 SEP 9 - 1948 (Date received by registrar) (b) [illegible] Registrar

VS 150 City Disposal [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from September 3 1948, to Sept 4 1948, and that I last saw him alive on Sept 4 1948.

	Duration
Immediate cause of death Prematurity	
Due to Toxemia of Pregnancy Pre-Eclampsia	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Laborn M. D.
Address University Hospital Date signed 9-8-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666677 BC-48-07257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. 666677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD SISK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 4 | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 5:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Malnutrition

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-28-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666678 BC-18-1660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

666678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1875 6. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Frederick
3 (b) If veteran, name war
3 (c) Social Security Account No
4. Sex F
5. Color or race Negro
6 (a) Single, married, widowed, or divorced Infant
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr 8/8/48
8. AGE: Years | Months | Days 2 | If less than one day hr min
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Frederick
13. Birthplace Lynchburg, Va.

MOTHER
14. Maiden Name Alicia Sturgeon
15. Birthplace Richmond Co. Va.

16 (a) Informant Mrs. Alicia Frederick
(b) Address 1875 E. Chase St., Balto., Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University National School SEP 2 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) SEP 9 - 1948 (Date received by registrar) (b) Huntington Maryland, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948 at 9 55 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1948 to 9/1 1948 and that I last saw him alive on 9/1 1948.

Immediate cause of death: Respiratory failure — Duration
Due to Prematurity
Due to
Other Conditions (Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo H. Sudlow
Address 1100 Hoy. Date signed 9/1/48

VS 150

066679 KS-1P6 K3 ✓ 066679

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Sts.
(c) Hospital or institution: Hosp. for Women of Md. 27 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Woodbourne Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hedden

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1948

8. AGE: Years	Months	Days	If less than one day
			1 hr. 21 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Alver Hedden
13. Birthplace Jamesonville, New Jersey

MOTHER
14. Maiden Name Sadie Marguerite Patton
15. Birthplace Hatfield, Pennsylvania

16 (a) Informant Mrs. James A. Hedden
(b) Address 2004 Woodbourne Ave, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (SEP 9 - 1948) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948 at 4 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1948 to 9-1-1948.
and that I last saw him alive on 9-1-1948.

Immediate cause of death Anoxemia — Duration

Due to Congenital atelectasis

Due to

Other Conditions maternal — partial premature separation of placenta
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Spencer M. D.
Address Hosp. for Women of Md. Date signed 9-2-48

VS 130

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66680 BC-48-1908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G66680

Physicians: please write the causes of death clearly and legibly. Give age as exactly as possible.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balt. Gen. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hr 20mm
(e) Length of stay in Baltimore (yrs., mos., or days) 4hr. 20mm

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 W. Balt. (If rural give number of road)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Son of Clarence & Geraldine Neal - A.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 9|5|48
8. AGE: Years | Months | Days | If less than one day 4 hr 20 min.
9. Birthplace So. Balt. Gen. Hosp. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Clarence
13. Birthplace Baltimore

MOTHER
14. Maiden Name Geraldine Brown
15. Birthplace Baltimore

16 (a) Informant Geraldine Neal
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] SEP 8 1948

18 (a) Funeral director [illegible]
(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9|5|48 (month) (day) (year) at 3:20 P.M.
21. I certify that death occurred on the date stated, that I attended deceased from 10:59 A.M. 9/5/48 to 3:20 P.M. 9/5/48 and that I last saw him alive on 9|5|48

Immediate cause of death (Strangulation (Hanging))
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration
4 hr.
20 mm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. Macdonald
Address 213 Light St. Date signed 9-5-48

VS 150

G66681

DS-

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 10, 1879

8. AGE: Years	Months	Days	If less than one day
68	8	16	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin (D)
13. Birthplace ?

MOTHER
14. Maiden Name Frances McKin
15. Birthplace ?

16 (a) Informant RECORDS* Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location [redacted] SEP 8 1948

18 (a) Funeral director [redacted]

(b) Address [redacted]

19 SEP 9 - 1948 (Date rec'd by registrar) [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 19 48, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 19 48 to 8-26 19 48
and that I last saw him alive on 8-26- 19 48

Immediate cause of death: Far advanced bilateral Tuberculosis of Lungs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 4 years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Earle Burton
Address Balto City Hosp Date signed 9-3-48 M. D.

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66682

GM. 82666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G66682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Von Daniel Veltman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Cornelia (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22- 1862

8. AGE: Years	Months	Days	If less than one day
85	8	27	hr. min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sidney Veltman
13. Birthplace Holland

MOTHER
14. Maiden Name Bertha Baker
15. Birthplace Holland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) SEP 9- 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 18- 19 48, 2.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 16- 19 43 to 8- 18- 19 48 and that I last saw h im alive on 8- 18- 19 48.

Immediate cause of death	Duration
Probable bronchopneumonia	2 days
both lungs Edema	
Due to Arteriosclerosis of	
Cardio-vascular disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirkendall M. D.
Address Balto City Hosp Date signed Sept 48

VS 150

X

666683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. 666683

BM. 121628

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 18 N. Bond ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** John Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1 - 1883

8. AGE: Years	Months	Days	If less than one day
65	4	17	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Johnson

13. Birthplace ?

MOTHER

14. Maiden Name Ida ?

15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address Baltimore, Md.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 18 - 1948 at 5.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 28 -1948 to 8- 18 -1948, and that I last saw h alive on 8- 18 -1948

Immediate cause of death Cardio-resp failure — Duration mins.

Due to ? CVA. — Duration mins.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/3/48

Major findings of operation: Papilloma of anus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jordan Small M. D.

Address Balt City Hosp. Date signed 8/31/48

VS :50

Hal 3

684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G66684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La. (b) County
(c) City or town Shreveport (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 Stoner Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME David Armond Eames

3 (b) If veteran, name war | 3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-46

8. AGE: Years	Months	Days	If less than one day
1	10	23	hr. min.

9. Birthplace La (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Armond Eames
13. Birthplace Ala.

MOTHER
14. Maiden Name Jessie Mae Gleason
15. Birthplace La

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Shreveport, La Cemetery
Location

18 (a) Funeral director Chas P Powell
(b) Address 2417 Edmondson Ave

19 (a) SEP 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1945, at 5 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1945, to 9-9 1945, and that I last saw him alive on 9-9 1945.

Immediate cause of death. Cerebral Anoxia — Duration

Due to Tracheal obstruction

Due to Congenital vocal cord paralysis

Other Conditions Tetralogy of Fallot, post operative
(Include pregnancy within 3 months of death)

Date of operation 9/8/45 Fatal

Major findings of operation: Pulmonic Stenosis

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Henry T. Sahmon M.D.
Address 1 Hill Date signed 9/9/45

G66685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G66685
Registered No.

AB -11906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 48years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Exter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adaline Bottdorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Benjamine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept- 15-1859

8. AGE: Years	Months	Days	If less than one day
88	11	13	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dr. John Nevins
13. Birthplace ?

MOTHER
14. Maiden Name Esther Brown
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 1948 at 12.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3- 1934 to 8-28- 1948, and that I last saw her alive on 8-28-48 1948.

Immediate cause of death: Lobar pneumonia — Duration: 1 day

Due to

Due to

Other Conditions Hypertension, Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Nechtold M. D.

Address [illegible] Baltimore City Date signed 9-8-48

G66686

426999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

✓ G666686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Hastings.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Emma Hastings

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 4-4-88

8. AGE: Years 60 | Months 4 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Braxton Hastings

13. Birthplace Va.

MOTHER 14. Maiden Name Harriet Simon

15. Birthplace Md.

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 9 - 1948 (Date rec'd by Registrar) (b) ... (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 27 - 1948. at 11 5-8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 - 1948. to 8-27 - 1948.
and that I last saw him alive on 8-27 - 1948.

Immediate cause of death Pneumonia — Duration 1 week

Due to Bronchiectasis — 1 yr

? Cancer of lung — 2 yrs

Due to Malnutrition
Cachexia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Thomas M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9/2/48

VS 150

G66687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

32a

G66687

Registered No.

BS-122123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John Gross

6 (c) If alive, give age 1922??

7. Birth date of deceased (mo., day, yr.) July 4, 1927

8. AGE: Years	Months	Days	If less than one day
21 or 26 yrs.	11	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Jones
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 8 1948 (Date rec'd by registrar) (b) Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1948 to 8-16 1948, and that I last saw her alive on 8-16 1948

Immediate cause of death Probable Infectious Hepatitis — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp Date signed 9-8-48

VS 150

G666688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G666688 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Marmon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Marmon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Ann Lacey
3 (b) If veteran, name war — 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Edwin Young Lacey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 31st 1865
8. AGE: 83 Years | Months | Days | If less than one day hr. min.
9. Birthplace Clinton Ohio (Town, county, and state)
10. Usual Occupation Bore
11. Industry or business

FATHER
12. Name Peter Casen Lisor
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Arni
15. Birthplace Germany

16 (a) Informant Mrs Clinton H. McLutz
(b) Address 3702 Marmon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Baltimore Md

18 (a) Funeral director Wallis Lampman
(b) Address 4510 Liberty Heights Ave

19 (a) 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1948, at 11.45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1943, to Sept 1948, and that I last saw h[illegible] alive on 9-9-1948.

Immediate cause of death	Duration
Coronary Occlusion	1 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Harper M. D.
Address 5201 Fairmount Ave Date signed 9/9/48

Homer J. Harper, M.D.

CAUTION: [illegible] Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 164a

G66689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estella SPROUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1926

8. AGE: Years 21 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ALONZO SPROUSE
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name ESTER COLEMAN
15. Birthplace VIRGINIA

16 (a) Informant: MR ROY BOARDMAN
(b) Address 1725 HOLLINS ST

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof SEPT 9, 1943 (month) (day) (year)
(c) Cemetery or crematory
Location RICHMOND VIRGINIA

18 (a) Funeral director Henry A. Wyche
(b) Address 4101 E. Richmond Rd.

19 (a) SEP 9 1943 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1943, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sep. 8, 43 at 8 P.M.
(b) Where did injury occur? Jail, Western Dis. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? no
(d) Means of injury hanged self with clip to bars

23. Signature George N. Morrell M.D. Medical Examiner.
Date signed 9-9-43

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

666690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4807 Richard Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Richard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Johnson Chamberlain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Helen L. Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1891

8. AGE: Years	Months	Days	If less than one day
57	-	12	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Gas & Elec. Co.

FATHER
12. Name Benjamin S. Chamberlain
13. Birthplace Md

MOTHER
14. Maiden Name Mary Howard
15. Birthplace Md

16 (a) Informant Mrs. Helen L. Chamberlain
(b) Address 4807 Richard Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 9 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948 at 12:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McSadden M.D.
Medical Examiner.
Date signed 9-9-48

VS 181

G66691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52a.

G66691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Giunta

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9488

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Mary Giunta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 6th 1879

8. AGE: Years 69 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Piano Finisher

11. Industry or business Retired

FATHER 12. Name Charles Giunta

13. Birthplace Italy

MOTHER 14. Maiden Name Anneta Pistorio

15 Birthplace Italy

16 (a) Informant Chas. T. Giunta

(b) Address 1712 E. 2nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)

(c) Cemetery ~~cemetery~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1219 St. Paul St.

19 (a) SEP 9 - 1948 (Date received by registrar) Huntington Harrison (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1948 to 3-25 1948, and that I last saw him alive on 3-25 1948.

Immediate cause of death: Hyper nephroma, right Kidney with metastases ~~Due~~ to lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

Duration: ??

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Singwald M. D.

Address 1109 St Paul St Date signed 9/7/48

VS 150

666692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

666692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 Gwynn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Gwynn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa V. Purcell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) Dec 24th 1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	8	14		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Patrick Purcell
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Joyce
15. Birthplace Ireland

16 (a) Informant Mrs Thomas Cullaran
(b) Address 433 Gwynn Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 121 St. Paul St.

19 (a) SEP 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1948, at 8 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to 9/8 1948, and that I last saw h~~er~~ alive on 9/7 1948.

Immediate cause of death: General Visceral Failure
Due to: Generalized Arterio Sclerosis
Arteriosclerotic Cardiovascular Disease

Duration
9/1/48
2 yrs +
2 yrs +

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 3629 Elmondale Dr Date signed 9/9/48 (M.D.)

VS 150

G666693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 464

G666693
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 East Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 East Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Agnes Miner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William J. Miner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 12, 1878

8. AGE: Years 70 | Months 2 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Cornelius Trainor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Kern
15. Birthplace: Ireland

16. (a) Informant: Mrs. Helen O'Connor
(b) Address: 713 East Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: Rita Fiedefeld
(b) Address: 900 East Biddle St

19 SEP 10 1948 (Date received by Registrar) Huntington Mitchell, M.D. (Registrar)

VS. 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept 1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Sept. 9 1948, and that I last saw her alive on 8 Sept. 1948.

Immediate cause of death: Retroperitoneal sarcoma — Duration: 2 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Louis E. Wice, M.D.
Address 920 St. Paul Date signed 9 Sept. 48

X

G66694 48-19397 ✓ G66694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 ST. PAUL ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BABY CHARLES NORTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	WHITE	SINGLE

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-8-48

8. AGE: Years	Months	Days	If less than one day
—	—	—	23 hr. 50 min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER 12. Name RICHARD NORTON
13. Birthplace MARYLAND

MOTHER 14. Maiden Name [illegible]
15. Birthplace MARYLAND

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 10 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 9 1948, at 2 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948, to 9-9 1948 and that I last saw him alive on 9-9 1948.

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions: Anoxia Fatal distress, Abnormal umbilical cord.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D Brown M.D.
Address Johns Hopkins Hosp. Date signed 9-9-48

VS 159

666695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 666695

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac L Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1883

8. AGE: Years 64 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Jewelery Business

FATHER
12. Name Louis Livingston
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Jules Livingston
(b) Address 2509 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Rogers Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by Local Registrar SEP 10 1948 (b) Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 11 - M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 8 1948 and that I last saw him alive on Sept 8 1948.

Immediate cause of death: Ac. Coronary Thrombosis — Duration

Due to Hypertensive - Arteriosclerotic C.V.H.D

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applegarth, M.D.
Address 251[illegible] Reisterstown Rd Date signed 9/9/48

X

666696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1/8
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or institution (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Oakmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Yerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years: 69 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Mordecai
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dora
15. Birthplace: Russia

16 (a) Informant: Solomon Yerman
(b) Address: 3607 Oakmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2166 Eutaw Place

19 SEP 10 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1948 at 7 20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/5 1948 to 9/10 1948 and that I last saw he alive on 9/10 1948

Immediate cause of death: Cor Pulmonale — Duration

Due to: Pulmonary Fibrosis

Due to: Bronchiectasis, Chronic

Other Conditions: Old Tuberculosis, Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edward A Epper M.D.
Address: Sinai Hospital Date signed 9/10/48

VS 150

106 R

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CARTER

166697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 166697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Resident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 W. Mulberry (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Roberta Carter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Edward Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/30/[illegible]

8. AGE: Years 39 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Nanna Harvod
15. Birthplace Md.

16 (a) Informant Edward Bell
(b) Address 2124 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Pleasant

18 (a) Funeral director C. Halstead Gillam
(b) Address 915 Linden Ave

19 SEP 10 1948 (Date received by Registrar) (b) Evelyn M. Covington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 1205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1948 to 9-5 1948 and that I last saw her alive on 9-3 1948

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to Cardiac Enlargement
Due to
Other Conditions Marginal Pulmonary Edema
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. E. Bradley M.D.
Address 1514 Division St Date signed 9-7-48

VS 150

666698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

926

Registered No. 666698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 245 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HAZELTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Isabettie Hazelton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1908.

8. AGE: Years 40 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Hazelton.
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie
15. Birthplace Md.

16 (a) Informant: Catherine Reaves.
(b) Address 245 N. Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Tytie R. Wiltbight
(b) Address 322 N Schroeder St

19 SEP 10 1948 (Date rec'd by Registrar) Huntington Nathaniel, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948, at 5.15PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of heart

Due to Chronic valvulitis - mitral & aortic

Due to Chronic vegetation, mitral.

Other Conditions Adrenal tumor

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed September 8, 1948

VS 191

G66699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Loch Raven Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Loch Raven Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE SEMMLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles A. Semmler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1858

8. AGE: Years 90 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Sulthaus
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kaiser
15. Birthplace Germany

16 (a) Informant Mr. Frederick Siebert
(b) Address 4220 Loch Raven Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 SEP 10 1948 (Date received by Registrar) (Signature) for Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 8, 1948, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948, to 8 Sept. 1948. and that I last saw h.e.r alive on 8 Sept. 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Arteriosclerotic Cardio Vascular Disease	
Due to With Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 51 W. Chesapeake Ave. Date signed 9-9-48.

VS 150

X

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

666700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. 666700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 S. Conklin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Conklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA ELLEN DAVIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles W. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1874

8. AGE: Years 74 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Saunders
13. Birthplace Virginia

MOTHER
14. Maiden Name Robinette Broach
15. Birthplace Virginia

16 (a) Informant Mrs. Emma Richardson
(b) Address 711 S. Conklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1943, to Sept 8 1948, and that I last saw h.. alive on Sept 7 1948.

Immediate cause of death
Anemia - Sept 8
Pernicious Anemia Sept 8
Due to My Cancers
Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1948
1948
1943
1942

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin G. [illegible] M. D.
Address 3426 Bank St. Date signed 9/9/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

666701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 N. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Boddie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 23, 1910

8. AGE: Years 37 Months 9 Days 16 If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Unemployed Laborer

11. Industry or business

FATHER 12. Name William Boddie

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Boddie

15. Birthplace N. C.

16 (a) Informant William Boddie

(b) Address 1816 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/18 (month) (day) (year)

(c) Cemetery or crematory

Location Rocky Mt N. Carolina

18 (a) Funeral director Wm. Robert G. Ellis & Son

(b) Address 1098 N. Carlton St

SEP 10 1918 (Date received by registrar) (b) Washington, D.C.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/18 19 at 7:50 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(c) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Dare M.D. Medical Examiner.

Date signed 9/9/18

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

666702 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Caroline Dot St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Waugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1901

8. AGE: Years 47 | Months 6 | Days " | If less than one day hr. min.

9. Birthplace Oxford N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mark Parham

13. Birthplace N. C.

MOTHER 14. Maiden Name Isabelle Parham

15. Birthplace N. C.

16 (a) Informant Mazzie Clark

(b) Address 114 S Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day)

(c) Cemetery or crematory Mt Calvary Cem

Location A.A. County Md.

18 (a) Funeral director Mrs Pott & Edmonds Dept

(b) Address 112 N. Caroline St

19 (a) Date received (Registrar) (b) Registrar Washington Hennegan M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pyelonephritis

Abdominal urinary fistula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22 If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. C. Sulmonetti M.D. Medical Examiner.

Date signed 9/7/48

VS 151

G66703

Weinberger

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G66703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Moravia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Moravia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine H. Steininger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie - nee Lebrad

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 18-1876

8. AGE: Years 71 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Steininger

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Lipple

15. Birthplace Germany

16 (a) Informant Mrs. Annie Steininger

(b) Address 3313 Moravia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 13 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

19 (a) SEP 10 1948 (Date received by Registrar) (b) Burlington Wisconsin

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1946 to 9-8- 1948 and that I last saw h[illegible] alive on 9-8- 1948.

Immediate cause of death: myocardosis — Duration

Due to: Arteriosclerotic cardiovascular disease

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Gould M. D.

Address 1411 E. 31st Date signed 9-10-48

66704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 66704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Hamilton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evan O. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Frances T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-15-1870

8. AGE: Years 77 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Evan O. Edwards
13. Birthplace Wales

MOTHER 14. Maiden Name Ada Young
15. Birthplace N.J.

16 (a) Informant Frances T. Edwards
(b) Address 2401 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location

18 (a) Funeral director Lawrence J. Mugler
(b) Address 4205 Wenfield Rd.

19 (a) SEP 10 1948 (Date rec'd by registrar) (Registrar)

Burlington Philadelphia

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Sept 8 1948, and that I last saw him alive on Sept 6 1948.

Immediate cause of death: Myocardial insufficiency

Due to

Due to

Other Conditions: Arteriosclerosis, hypertension, myocardiopathy
(Include pregnancy within 3 months of death)

Duration

Date of operation —

Major findings of operation: —

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury —

23. Signature John L. Schlemmer
Address 1837 S Charles St Date signed 9/8/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

Legibility: Imperative: please write the causes of death clearly and legibly.

666705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun.
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Non Res
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida LEITH
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 29 Apr 83
8. AGE: Years 65 | Months 4 | Days 11 | If less than one day hr. min. 10
9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Retired Housewife
11. Industry or business

FATHER
12. Name Mason Walker
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mildred A Hergerman
15. Birthplace W. Va.

16 (a) Informant Mrs. W. J. Walker
(b) Address 1305 Poplar Grove St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory White
Location Balto. Md.
18 (a) Funeral director Charles P. Powell
(b) Address 2417 Edmondson Ave
19 (a) SEP 10 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sep 1948, at 11 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sep 1948 to 9 Sep 1948, and that I last saw her alive on 9 Sep 1948.

	Duration
Immediate cause of death Pulmonary Embolism	2-3 hrs.
Due to Phlebo Thrombosis R. Leg.	4 wks.
Due to	
Other Conditions Asthma. allergic (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury
23. Signature Roman V. Cullen M. D.
Address Franklin Sq. Hosp Date signed 9-10-48

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

666706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 666706

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)

(d) Street No. 407 Elmo St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Helen Catherine Zellers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife: Adam Edward Zellers

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) 2/3/1892

8. AGE: Years	Months	Days	If less than one day
56	7	6	hr. ____ min. ____

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House-Work.

11. Industry or business At Home

FATHER

12. Name Joseph Zuchowski

13. Birthplace Poland.

MOTHER

14. Maiden Name Mary ?

15. Birthplace Poland

16 (a) Informant Adam E. Zellers

(b) Address 407 S. Elmo St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem. Location German Hill Rd.

18 (a) Funeral director Charles S. Zeiler

Address 991 S. Conkling St.

SEP 10 1948

19 (a) ____ (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 4:35 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 22 1948 to Sept 9 1948 and that I last saw him alive on Sept 9 1948

Immediate cause of death	Duration
Myocardial Failure	
Due to Generalized Toxemia	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature Ray C. Pusono M.D.

Address St. Joseph's Hosp. Date signed 9/9/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

B 66707 — Registered No. B 66707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr. 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 1408 Rosedale St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Rose A. McGonigal
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife James Thomas McGonigal (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept. 29, 1871
8. AGE: Years 76 | Months 11 | Days 10 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Ridgely
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Maryland

16 (a) Informant Thomas M. McGonigal
(b) Address 1408 Rosedale St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/48 (month) (day) (year)
(c) Cemetery or crematory Harmony Lawn Location Howard Co. Md.
18 (a) Funeral director Eastern Stone
(b) Address Ellicott City Md.
SEP 10 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948 at 3 A M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 9-9 1948, and that I last saw h[illegible] alive on 9-9 1948.

Immediate cause of death
(a) Acute Pulmonary Edema — Duration 1 day
Due to Hypertension C-V-D — 1 year
Due to Cerebral Hemorrhage — 15 min.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature Leo Galiman M. D.
Address 20, Regular Ave. Date signed 9-7-48

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

666708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. West
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Wm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/73

8. AGE: Years 75 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER: 12. Name Joseph Nichols
13. Birthplace md

MOTHER: 14. Maiden Name Annie M. Cassell
15. Birthplace md

16 (a) Informant Mrs. Emma West
(b) Address 803 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Preastman St

19 (a) Filed [illegible] (Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1948 to Sept 8 1948
and that I last saw h alive on Sept 8 1948

	Duration
Immediate cause of death Chr. Myocarditis	9 m
Due to Pulmonary Embolus	2 dy
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Woodland M. D.
Address 801 Edmondson Ave Date signed 9-8-48

CHARLES WOODLAND

VS 21

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Whatcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street and No. 1216 Whatcoat St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fauna Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Wm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/1909

8. AGE: Years 39 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Wm Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Henrietta Jones
15. Birthplace Va

16 (a) Informant Wm Jones
(b) Address 1216 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/46 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Filed by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1946 at 6A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/3 1946 to 9/9 1946, and that I last saw him alive on 9/8 1946

Immediate cause of death — Duration

Due to Pulmonary

Due to Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Rhetta

Address 2135 Druid Hill Ave Signed 9/9/46

B. M. RHETTA X

VS 190

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G66710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G66710
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Bloom St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6669

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Ennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1893

8. AGE: Years 54 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Usa (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Little
13. Birthplace Usa

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ennie Little
(b) Address 533 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1302 Druid Hill Ave

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 8:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilation of heart.
Edema of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

Mal 4
G66711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30

G6671T
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N Dallas St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Missie Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr) 3-11-81

8. AGE: Years	Months	Days	If less than one day
67	5	29	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Spell
13. Birthplace N.C.

MOTHER
14. Maiden Name Fabbie ?
15. Birthplace N C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory Greenville, N.C.
Location Greenville N.C.

18 (a) Funeral director Leo. H. Nelson
(b) Address 130 3 Eastman St

SEP 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948, at 6 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948 to 9-9 1948 and that I last saw her alive on 9-9 1948.

Immediate cause of death: Internal Hemorrhage, Thoracic
Due to: Aneurysm of Aorta
Due to: Syphilis
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 days
7 years
Many years.

Date of operation August 31, 1948
Major findings of operation: Attempt to wire aneurysm
of autopsy: Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature David C. Sorster Jr. M.D.
Address Johns Hopkins Hosp Date signed 9/9/48

G66712 OC-48-19538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balto. Gen. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs. 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs. 10 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4236 6th St. B. C. H. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daughter of Roy & Mamie Bolyard.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/9/48

8. AGE: Years | Months | Days | If less than one day 5 hr. 10 min.

9. Birthplace S. B. G. H. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Roy Bolyard
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Mamie Bolyard
15. Birthplace W. Virginia

16 (a) Informant Mamie Bolyard
(b) Address W. Virginia

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 10 48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, Inc
(b) Address 715 LIGHT ST - 30

19 (a) (Date received by registrar) (b) Registrar

SEP. 10 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/48 19 at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3:16 P.M. 9/9/48 to 8:25 P.M. 9/9/48 and that I last saw h e alive on 9/9 19 48.

Immediate cause of death Atelectasis
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 5 hrs. 10 min.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence a M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1864 Date signed 9/9/48

Vs 150

Please write plainly, especially important. Physicians: please write the causes of death clearly and legibly.

G66713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 PATAPSCO AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 PATAPSCO AVE BALTIMORE, MD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT PEDDLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife FRANCES NOSEWORTHY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB 25, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	13	hr. min.

9. Birthplace NEWFOUNDLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business RETIRED

FATHER
12. Name SAMUEL PEDDLE
13. Birthplace NEWFOUNDLAND

MOTHER
14. Maiden Name SELINA PEDDLE
15. Birthplace NEWFOUNDLAND

16 (a) Informant MRS FRANCES PEDDLE
(b) Address 411 PATAPSCO AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 11 48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY
18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST - 30

SEP 10 1948 (a) (b) (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/1948, at 9:? M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Sept 8 1948 and that I last saw him alive on Sept 8 1948.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to Hypertension

Other Conditions Blephrosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Kahn M. D.
Address 203 Valley Date signed

G66714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Harford Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Michael J Casey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-8606

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 11/4/880

8. AGE: Years	Months	Days	If less than one day
60	10	4	hr. min.

9. Birthplace Ireland (town, county and state)

10. Usual Occupation Retired Watchman

11. Industry or business Locke Insulator Corp.

FATHER
12. Name Thomas Casey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dugnan
15 Birthplace Ireland

16 (a) Informant Mrs. Edna B. Knepper (niece)
(b) Address 2921 Hillcrest Ave., Balto 14, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon. Sept 13, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director J. Howard Brown
(b) Address 1405 Charles St Balto 3 Md

19 (a) [illegible] (Registrar) (b) Registrar

Hamilton Hillcrest, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed 9/8/48 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948, to Sept 8 1948, and that I last saw h/ alive on Sept 8 1948.

Immediate cause of death	Duration
Acute peritonitis	
Rupture of sigmoid	
Due to Intestinal obstruction	
Due to Ca of sigmoid colon	
Other Conditions Ventral hernia, Diaphragm Hernia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: [illegible]

of autopsy: Acute peritonitis, Ca sigmoid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Arcuti
Address Mercy Hosp Date signed 9/9/48

G66715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66715
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DAVID THOMAS WORK

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Alice Work

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 10, 1860

8. AGE: Years: 88 Months: 4 Days: 28 If less than one day: hr. min.

9. Birthplace: Cecil Co., Md.
(Town, county, and state)

10. Usual Occupation: Retired Signalman

11. Industry or business: B. & O. R. R. Co.

FATHER
12. Name: David Work
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden Name: Sarah Butler
15. Birthplace: Cecil Co., Md.

16 (a) Informant: Mr. Joseph W. Work
(b) Address: 639 Plymouth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 15 '48 to Sept 8 '48, and that I last saw him alive on Sept 7 '48.

Immediate cause of death: Chronic hypertension + Arteriosclerosis — Duration: yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Henry C. Houck, M.D.
Address 1934 Wyndhurst Ave. Date signed 9/9/48

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

666716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87E

Registered No. 666716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 10, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 West 39th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David June Carver Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of ~~husband~~ wife Catherine Carver.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 24 1916

8. AGE: Years 32 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Apprentice Broker

11. Industry or business

FATHER 12. Name David J. Carver Sr.
13. Birthplace Tennessee

MOTHER 14. Maiden Name Hallie Council
15. Birthplace Virginia

16 (a) Informant Mr. David J. Carver
(b) Address 217 Chancery Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Fairfax Courthouse Cem.
Location Fairfax, Va.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1918 Eutaw Pl.

19 (a) SEP 10 1948 (Date rec'd by registrar) Huntington Woods Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 5:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 9 1948, and that I last saw him alive on Sept 9 1948.

Immediate cause of death Intracranial hem, left parietal lobe,
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 9/5/48
Major findings of operation: Intracranial hem, left parietal lobe,
of autopsy Intracranial hem, left parietal lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grow M.D.
Address Union Memorial Hospital Date signed 9/9/48

VS 150

X

G66717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66717

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Clearview ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Clearview ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Brougher

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry F. Brougher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21. 1884

8. AGE: Years	Months	Days	If less than one day
63	8	19	hr. min.

9. Birthplace Harrisburg, Pa
(Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Godfrey Yoke
13. Birthplace Pa

MOTHER
14. Maiden Name Alice Cripple
15. Birthplace Pa

16 (a) Informant Mr. Harry F. Brougher
(b) Address 3007 Clearview ave

17 (a) Burial (b) Date thereof 9/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Gregory H. Bligh, Jr.
(b) Address 6009 Harford Road

19 (a) SEP 10 1948 Registered No. Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948 at 7:57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948. to Sept. 9, 1948 and that I last saw h alive on Sept. 9, 1948.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 48 hr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.
Address 7101 Harford Rd Date signed 9/10/48

VS 150

G66718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66718

163B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Aiken St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER V. SMITH, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1924

8. AGE: Years	Months	Days	If less than one day: hr.	min.
24	0	21		

9. Birthplace Washington D C (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Walter V. Smith Sr
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Agnes M Sylvester
15. Birthplace Frederick Md.

16 (a) Informant Walter V. Smith Sr.
(b) Address 2300 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Balto Md

18 (a) Funeral director Leonard J. Koch
(b) Address 3 and Hartford Road
Huntingtown Williamsport, Md.

SEP 10 1948 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1948, at 9:05 AM

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
CARBON DIOXIDE
Due to Barbiturate Poisoning
Effects
Other Conditions Mental depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/6/48 at P. M.
(b) Where did injury occur? 2300 Aiken St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Ingestion of sleepin tablets

23. Signature Homer J. Madeira M.D.
Medical Examiner.
Date signed 9/10/48

066719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 066719

AR-121653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 76yearrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ryan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr Oct. 23-1871

8. AGE: Years 76 | Months 10 | Days 16 | If less than one day: hr min

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name William Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Howard
15. Birthplace Scotland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) 9/11/48 burial Date thereof 9/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location Balto. City.

18 (a) Funeral director C. Vernon Emerson
(b) Address 4611 Park Heights Ave.

19 (a) Filed by [illegible] (b) Registrar Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9- 1948 at 7.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-29 1948 to 8-9- 1948, and that I last saw her alive on 9-9- 1948

Immediate cause of death: Pulmonary Embolism Cerebral Vascular accident — Duration

Due to

Due to

Other Conditions Fracture neck of femur subcutaneous
(Describe pregnancy if within 3 months of death)

Date of operation 8/2/48

Major findings of operation: Fracture neck of femur

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2nd 8
(a) Accident, ~~suicide or homicide~~
(b) Date of occurrence 7-28-48 at 4 P. M
(c) Where did injury occur? Baltimore St. near Beaconsfield (Specify whether in home, factory, street, farm, or other public building)
(d) Did injury occur about home, on farm, industrial place, or while at work? in street
(Specify type of place)
(e) Means of injury slipped & fell to ground

23. Signature H. J. Moulton M.D.
Address Baltimore City Hospitals Date signed 9/9/48

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER for B.J.S. ordered by H. J. Moulton M.D.

666720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 666720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Fernhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MR WILLIAM A. MURRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-1870

8. AGE: Years	Months	Days	If less than one day
78	5	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John A. Murray
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Susan Bien
15 Birthplace Peqna.

16 (a) Informant Mary Catherine Murray
(b) Address 418 E. Fernhill Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (Date received by Registrar) (b) Huntington Mathews, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-1948, at 1:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6 1948 to 9-8 1948, and that I last saw h alive on 9-8 1948.

Immediate cause of death Cardiac failure — Duration

Due to Coronary infarction acute

Due to Coronary atherosclerosis and chronic hypertensive myocardial

Other Conditions Mitral insufficiency. Pleural adh. at

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) State
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Siva M.D.
Address Mercy Hosp Date signed 9-8-48

VS-150

66721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 66721

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23rd St
(c) Hospital or institution: Beck's Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. 20th. St.
(If rural give location)
(e) Citizen of foreign country? —— (Yes or No)
If yes, name country

3 (a) FULL NAME James K. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1895

8. AGE: Years 52 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Valuator,

11. Industry or business Home Owners Loan Corp.

FATHER
12. Name James B. Smith,
13. Birthplace Va.

MOTHER
14. Maiden Name Ella Jane Kelly,
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helen Smith,
(b) Address 521 E. 20 th. St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Balto. City.

18 (a) Funeral director C. Vernon Lawrence,
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948, to Sept 9 1948, and that I last saw him alive on Sept 9 1945.

Immediate cause of death — Tuberculosis of lungs Acute — Duration Indefinite

Due to Malnutrition & Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M. Beck M.D.
Address 100 E. 23rd St Date signed Sept 9, 48

VS 150

Clemmon

X

66722

B-121948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8-2 R

Registered No. 666722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Cutamony

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 57? Months Days If less than one day hr. min.

9. Birthplace Md? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 10 1948 (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1948 to 8-17 1948 and that I last saw him alive on 8-17 1948

Immediate cause of death CEREBRAL THROMBOSIS — Duration 9 DAYS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address Baltimore City Hosp. Date signed 8-25-48

VS 150

X

G66723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registration No. G66723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Mo. 15Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lossing, Alfred. Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1940

8. AGE: Years 8 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business Glen Burnie Elementary

FATHER
12. Name Alfred W. Lossing Sr.
13. Birthplace Detroit, Mich.

MOTHER
14. Maiden Name Ann M. Clarke
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Alfred W. Lossing Sr.
(b) Address 400 Central Ave., Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11, 48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas V. Singleton
(b) Address Glen Burnie, Md.

(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1948, at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25, 1948 to Sept. 8, 1948, and that I last saw him alive on Sept. 8, 1948.

Immediate cause of death: Subarachnoid Hemorrhage — Duration

Due to: Acute lymphatic leukemia

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Inman
Address Sinai Hospital Date signed 9/8/48

VS 150

666724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

666724 Registered No.

Type or print plainly in ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 abell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Sheets

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Alapius J Sheets
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 12/21/1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	8	19		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Montgomery
15. Birthplace Baltimore Md

16 (a) Informant Miss R Sheets
(b) Address 3218 abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Carlton
Location Old Frederick Rd

18 (a) Funeral director J J Tobey & Sons
(b) Address 618 Eighth St

19 SEP 11 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 9-10 1948.
and that I last saw her alive on 9-10 1948.

Immediate cause of death Adenocarcinoma of Colon — Duration 1

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilmer N. Fuesting M. D.
Address 11 E. Chase St. Date signed 9-10-48

VS 150

666725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666725

ES-

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Anna Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1869

8. AGE: Years 79 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Edmondson Ave. Rd.

18 (a) Funeral director J. J. Fahey Sons
(b) Address 131 E. Eight St. Huntington, W. Va.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-48 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8-33 to 8-26-48, and that I last saw her alive on 8-26-48

Immediate cause of death: Bronchopneumonia, bilat — Duration: 3 Days.
Due to Cerebral Vascular Accident — 2 yrs.
Due to Hypertensive Arteriosclerotic Heart Disease — 5-10 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Nichols M. D.
Address Balto City Hosp Date signed 9 Sep 48.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

666726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

V- 666726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Allendale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Wiseman - Stanley C. Weisman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213 05 6498

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Isabelle Bass

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1905

8. AGE: Years 43 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Carfall Laundry

11. Industry or business

FATHER
12. Name Chas. Weisman
13. Birthplace Md

MOTHER
14. Maiden Name Minnie Berger
15. Birthplace Md

16 (a) Informant Isabelle Weisman
(b) Address 713 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Taylor Ave. Balto. Md

18 (a) Funeral director Henry H. Kittle
(b) Address 1 Edmondson

19 9 8 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1948, at 5 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner.
Date signed 8-9-48

VS 151

666727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 Lehman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Lehman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NO

3. (a) FULL NAME Evalyn S. Miles

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ira B. Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 11, 1883

8. AGE: Years 65 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace: Wilmington, Del.
(Town, county, and state)

10. Usual Occupation: Home

11. Industry or business: Home

FATHER
12. Name: John Bennett
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Swacker
15. Birthplace: Wilmington, Del

16 (a) Informant: Clyde H. Miles
(b) Address: 3024 Raynor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 13, 48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 SEP 11 1948 (a) Date rec'd by Registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1948 to 9/10 1948 and that I last saw her alive on 9/9 1948.

Immediate cause of death: Uremia — Duration: 10 days

Due to: Chronic Nephritis & General Arteriosclerosis — 15 Months

Due to:

Other Conditions: Diabetes Mellitus — 15 Years
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Elias W. Solomons M.D.
Address 3432 Fredericks Ave. Date signed 9/12/48

131a

G66728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66728

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2246 E. Lehane St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 2246 E Lehane St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis L Baker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17th 1878

8. AGE: Years	Months	Days	If less than one day
70	6	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Section
11. Industry or business

FATHER
12. Name Wm B. Baker
13. Birthplace Md

MOTHER
14. Maiden Name Annie Hull
15. Birthplace Md

16 (a) Informant Mrs Annie Baker
(b) Address 2246 E. Lehane St.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Sept 15th 1948 (month) (day) (year)
(c) Cemetery or crematory Adolf Reddemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park ave

19 SEP 11 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1948, at 5.30 PM

21. I certify that death occurred on the date stated above, that I attended deceased from Jan 1 1948 to Sept 9 1948, and that I last saw him alive on Sept 9 1948

Immediate cause of death: Cerebro-Vascular Accident — Duration 17

Due to: Hypertension

Due to: Nephritis

Other Conditions: Acute Cardiac Dilatation
(Including pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about: home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Buzby M. D.
Address 704 N Patterson Park Ave Date signed Sept 10 1948

VS 150

666729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666729

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 813 N. Lakewood Ave

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 813 N Lakewood

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Jeanette B. Appel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edw. Appel 1878

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) June 2, 1878

8. **AGE:** Years 70 | Months 3 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Philip Mickinson

FATHER 13. Birthplace Balto

MOTHER 14. Maiden Name Mary Kessler

MOTHER 15. Birthplace Balto

16 (a) Informant Edw. Appel

(b) Address 813 N Lakewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Pleasant St Huntington Woodlawn, Md

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 11:30 PM (DST) M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948 to Sept 10 1948, and that I last saw h[er] alive on Sept 10 1948.

Immediate cause of death: Myocardial Infarction — Duration

Due to: Coronary Artery Sclerosis and

Due to: Luminal Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 5, 1948

Major findings of operation: Chronic Cholecystitis

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Vernon T. Norwood M. D.

Address Church Home & Hospital Date signed 9-11-48

Please age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. 128

VS 130

G66730

AB-122797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66730 Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): April 7-1902

8. AGE: Years: 46 | Months: 5 | Days | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Neilford Draughn
13. Birthplace ? Halifax Co. N.C.

MOTHER
14. Maiden Name Charlotte Draughn
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md.

18 (a) Funeral director Thos. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received by registrar SEP 11 1948 (b) Registrar's signature Wm. [illegible]

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8- 1948, at 10.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1948, to 9-8- 1948 and that I last saw her alive on 9-8- 1948.

Immediate cause of death Cerebro-vascular accident - apoplexy — Duration 2 hrs

Due to Chronic hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. F. Nelson
Address Balt City Hosp Date signed 9/9/48

666731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 666731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 N Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 247 N Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J Gross
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 8 1862
8. AGE: Years 85 Months 11 Days 1 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Samuel J Gross
13. Birthplace Md
MOTHER 14. Maiden Name Margaretta Moore
15. Birthplace Balto Md
16 (a) Informant Edith Gross
(b) Address 247 N Schroeder St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12 48 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Baltimore County
18 (a) Funeral director Donald L Brannon
(b) Address 1856 Montgomery St
19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 10 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Sept 9 1948, and that I last saw he alive on Sept 8 1948.

	Duration
Immediate cause of death Uremia	Unknown
Due to Chr. Glomerular Nephritis	Unknown
Due to	
Other Conditions Congestive Heart failure	Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Harland Thrift Jr M. D.
Address 902 W Franklin St Date signed 9-10-48

VS 150

Transcriber's Notes: Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66732

AB- 122726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66732

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 China St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Annie Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 5- 1905

8. **AGE:** Years: 43 | Months: - | Days: 3 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Sheppard Mills (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Lizzie Watkins (D
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Balto Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1018 W Montgomery St

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Huntington W Brown Funeral Director

MEDICAL CERTIFICATION

20. **DATE OF DEATH** September 8- 1948, at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-5- 1948 to 9-8- 1948 and that I last saw him alive on 9-8- 1948

Immediate cause of death: BILATERAL PULMONARY TUBERCULOSIS — Duration: 3 mo??

Due to

Due to

Other Conditions: PNEUMONIA
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP Date signed 9-9-48

VS 150

666733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1929

Registered No. 666733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 S. Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 S. Pulaski Street (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WILLIAM BYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELLA R. BYERS
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) OCT. 3 / 1877

8. AGE: Years	Months	Days	If less than one day
70	11	5	hr. min.

9. Birthplace BRIDGETON . . . IND.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name JESSIE BYERS
13. Birthplace IND.

MOTHER 14. Maiden Name KATHERINE WEBSTER
15. Birthplace IND.

16 (a) Informant MRS. ELLA R. BYERS (WIFE)
(b) Address 643 S. PULASKI STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 11-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE . . . 17

19 (a) SEP 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8 th. 1948 at 9:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 MAY 48 to 8 SEPT 1948, and that I last saw h[im] alive on 8 SEPT 1948.

Immediate cause of death	Duration
(a) CEREBRAL HEMORRHAGE	9 DAYS
Due to ARTERIOSCLEROSIS	
(b) CARDIO-VASCULAR DISEASE	1 YR
Due to ARTERIOSCLEROSIS	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury

23. Signature Edward J. Mc[illegible] M.D.
Address 682 WASHINGTON BLVD. (Date signed) SEPT 8 1948
BALTIMORE - 30 MD

PHYSICIAN
Underline the cause to which death should be charged statistically

Correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

66734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 66734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3rd floor 300 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine PARKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Separated

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1912

8. AGE: Years	Months	Days	If less than one day
35 36	11	5	hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Willie Springfield

13. Birthplace NC

MOTHER 14. Maiden Name Lucinda Worth

15. Birthplace NC

16 (a) Informant Lucinda Lunsford.

(b) Address 300 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial Park

Location

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) SEP 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1948 at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab-wound of lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 7, 48 approx. P. M.
(b) Where did injury occur? Rear of house above address
(c) Did injury occur at home, on farm, in business place, in public place? Home While at work? No
(d) Means of injury sharp instrument

23. Signature George E. Merrill M.D. Medical Examiner.

Date signed 9/8/48

VS 151

X

A666735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121B

Registered No. 666735

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Maryland Gen'l Hospital

(a) Baltimore City, Maryland

(b) Street address Madison St & Linden Ave

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4807 Norwood Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nelson Wendell Ningard

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eurith M. Ningard nee Blamberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 2-18-09

8. AGE: Years 39 Months 6 Days 21 If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: McDowell Pyle & Co.

FATHER 12. Name: Oliver Ningard

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden Name: Mary L. Wilson

MOTHER 15. Birthplace: Baltimore

16 (a) Informant: Mrs. Eurith M. Ningard

(b) Address: 4807 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge Cem. Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 11:58 AM

21. I certify that death occurred on the date above stated; that I attended deceased from [redacted] 1948, to 9-10 1948.

and that I last saw him alive on 9-10 1948.

Immediate cause of death: Cardio-respiratory renal failure — Duration: 2-3 mos

Due to: Chronic glomerulonephritis — Duration: 7 years

Due to:

Other Conditions: uremia, pulmonary edema hypostatic pneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Margaret Louise Cadle M. D.

Address Md. Gen'l Hosp. Date signed 9/10

X

666736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

956

666736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY ARLENE MUELLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Fred F. Mueller.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1913

8. AGE: Years 34 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas M. Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Florence Frey
15. Birthplace Glen Rock, Pa.

16 (a) Informant Mr. Fred F. Mueller
(b) Address 410 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948, to 9/10 1948, and that I last saw her alive on 9/10 1948.

Immediate cause of death Rheumatic heart disease — Duration

Due to (c) Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Judith B. Landau M. D.
Address Sinai Hospital Date signed 9/10

VS 150

Every item on this certificate should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666737

666737 48-18279 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-48

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Johnson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Irene Carter
15. Birthplace Middlesex Co. Va.

16 (a) Informant Joseph Johnson
(b) Address 1047 W. Fayette St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month, day, year)
(c) Cemetery or crematory Mt. Calvary
Location C. A. Co.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Eutaw St.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 10:45 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained. Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 9/11/48

VS 131

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G666738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 N. Gilmore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1644 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter B. Watson

3 (b) If veteran, name war: WW II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife: Rebecca Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1920

8. AGE: Years	Months	Days	If less than one day: hr.	min.
28	2	4		

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Seaman.

11. Industry or business

FATHER
12. Name Walter Watson
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie C. Vise
15. Birthplace Md

16 (a) Informant Fannie Watson
(b) Address 1644 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)

(c) Cemetery or crematory Balto nat
Location rvd

18 (a) Funeral director Hugo D. Nelson
(b) Address 203 Preistman St

19 Filed 9-11-1948 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1948 to 9/9/ 1948 and that I last saw h alive on 19

Immediate cause of death Gastro Intestinal Ulcer

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged scientifically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer J. Musacchio M.D.
Address 1775 Druid Park Dr Date signed 9/11/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G66739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Red Lion (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 W Broadway St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell E Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Mrs Viola A Miller

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Jan 14 1904

8. AGE: Years	Months	Days	If less than one day
44	8	27	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Bank Clerk

11. Industry or business

FATHER
12. Name Covington A. Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mabel Fry
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof SEPT. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory RED LION CEM.
Location RED LION, PENNA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 SEP 11 1948 Attesting for Williams, M.D. Registrar
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1948 to 9/11 1948, and that I last saw him alive on 9/11 1948.

Immediate cause of death Carcinoma, metastatic, to brain — Duration 6 mo.

Due to Carcinoma, prostato-seminal-rectal area — 6 mo to 4 yrs

Due to

Other Conditions Metastatic carcinoma, kidneys, bilateral
(Include pregnancy within 3 months of death)

Date of operation 9/10/48

Major findings of operation: edema of brain

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Edmund P. Grove M.D.
Address Union Memorial Hospital Date signed 9/11/48

VS .150

666740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Miami - 32 (If outside city or town limits, write RURAL and give town)
(d) Street No. 52 Biscayne Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. George Bullem George Bullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Georgianna Bullem

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1887

8. AGE: Years: 61 | Months: 6 | Days: 22 | If less than one day: hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation Traffic representative

11. Industry or business aviation transportation

FATHER
12. Name George Bullem
13. Birthplace Ontario, Canada

MOTHER
14. Maiden Name Lenore Nipon
15. Birthplace Tennessee

16 (a) Informant Mrs. Geo. Bullem
(b) Address 52 Biscayne Blvd. Miami, Fla.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Monumental, Md.
Location

18 (a) Funeral director Rifle Lawrence
(b) Address 450 Liberty Heights Ave.

19 SEP 11 1948 (b) Harrington Williamsport Md.
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Sept. 9, 1948, and that I last saw him alive on Sept. 7 1948.

Immediate cause of death	Duration
Coma arising due to unknown cause	
Due to Pneumonia of lung, left	3 mo. +
Due to	
Other Conditions pneumonectomy	

(Include pregnancy within 3 months of death)

Date of operation 9-9-48

Major findings of operation: Confirmed above

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Robert Hoare M. D.
Address Church Home & Hospital Date signed 9-9-48

VS 15)

666741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 666741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 Brohawn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Brohawn Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Molly Virginia Collins

Mollie Virginia Collins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife George W. Collins
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov-5-1884

8. AGE: Years 63 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Lathe
13. Birthplace Baltimore

MOTHER
14. Maiden Name Carry Harvey
15. Birthplace Baltimore

16 (a) Informant George W. Collins
(b) Address 2416 Brohawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director J. Kelly Gwozdecky
(b) Address 4510 Liberty Heights Ave

19 SEP 11 1948 (Date rec'd by Registrar) (b) Burrington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September-10 1948 at 12 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 9-9- 1948.
and that I last saw h alive on 9-9- 1948.

Immediate cause of death congestive heart failure
Due to Cardio Vascular-Renal disease
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 2 years

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Rd Date signed 9/10/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. Every blank must be filled in. Physicians: please write the causes of death clearly and legibly.

VS 150

G66742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G66742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Martinek

MEDICAL CERTIFICATION 50

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-80

8. AGE: Years 67 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business

FATHER 12. Name James Martinek
13. Birthplace Austria

MOTHER 14. Maiden Name Barbara Rytine
15. Birthplace Austria

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Lorraine Lane

18 (a) Funeral director Lilly & Zeller
(b) Address 4403 Harford Rd

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) [illegible] Registrar

20. DATE OF DEATH Sept 8 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1948 to 9-8-1948 and that I last saw living alive on 9-8-1948.

Immediate cause of death: Hemorrhage from
Due to: Gastro-intestinal
Due to: Tract (cancer)
Other Conditions
(Include pregnancy within 3 months of death)
Duration: 3 weeks

Date of operation 8/2/48
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Thomas V. P. Johns
Address Johns Hopkins Hosp. Date signed 9/7/48

VS 150

666743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 W 42nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 W 42nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles J Fallon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Vera B Fallon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1872

8. AGE: Years 76 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Pollack & Leo

FATHER 12. Name Charles J Fallon

13. Birthplace Baltimore

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Donald W Fallon

(b) Address 4518 Pennhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 1948 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Lutherville Md

18 (a) Funeral director Harry A Arnacost

(b) Address 4214 Ridgewood Ave Baltimore, Md

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1948, at 6:57 M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)

(d) Means of injury

23. Signature William J Helgrich M.D. Medical Examiner.

Date signed Sept 15, 1948

VS 151

666744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1276

Registered No. 666744

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Pulaski & Fayette

(c) Hospital or institution: Bon Secour Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 339 S. STRICKER St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET T. ROCK

3 (b) If veteran, name war

3 (c) Social Security Account No. none

Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Howard Rock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 1- 1864

8. AGE: Years 84 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation

11. Industry or business HOUSEWIFE

FATHER 12. Name JOHN C. GERBER

13. Birthplace Germany

MOTHER 14. Maiden Name Anna HARRIGAN

15. Birthplace Ireland

16 (a) Informant DAVID A. ROCK

(b) Address 339 S. STRICKER St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 13-1948 (month) (day) (year)

(c) Cemetery or crematory St VINCENTS

Location Balto MD

18 (a) Funeral director Robt C. & B.M. Walker

(b) Address Pratt & Stricker Sts

19 SEP 11 1948 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1948, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1948, to 9-7 1948, and that I last saw h alive on 9-7 1948

Immediate cause of death Respiratory Failure

Due to Pulmonary Edema

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Richard Lindsay Shipley, M.D.

Address Same Date signed 9-11-48

VS 190

G66745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56E

Registered No. G66745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & green sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Mullican

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-2547

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife not alive Louisa Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 15, 1872

8. AGE: Years 76 | Months 0 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business Mechanic

FATHER
12. Name James Mullican
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria Lane
15 Birthplace Md.

16 (a) Informant Mrs Emory Shipley
(b) Address 129 W. Patrick St, Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9-13-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

SEP 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 3.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1948 to 9-11-1948 and that I last saw him alive on 9-11-1948.

	Duration
Immediate cause of death Coronary thrombosis	
Due to Arteriosclerosis	
Due to Uremia	
Other Conditions { Benign prostatic Hypertrophy grade II Papilloma bladder	

(Include pregnancy within 3 months of death)

Date of operation 9/5/48
Major findings of operation BPH grade II
Papilloma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work):
(Specify)
(e) Means of injury

23. Signature W. A. Wiseman M. D.
Address Univ. Hosp. Date signed 9-11-48

VS 199

X

66746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. 66746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3332 Fairfield Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Dashiell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	col.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Eastern Shore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name George Deshields
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Sis. Deshields
15. Birthplace Eastern Shore Md

16 (a) Informant Sulena Deshields
(b) Address 3332 Fairfield Rd

17 (a) Burial (b) Date thereof Sept. 12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Tuxtie Cem.
Location Eastern Shore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 100 Bentley ave

19 (a) SEP 12 1948 Washington Hilliard, Reg.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2, 1948, to Sept. 9, 1948, and that I last saw him alive on Sept. 8, 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to ~~Coronary occlusion~~ Myocardial infarction	
Due to Coronary occlusion	
Other Conditions Benign prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation Sept 2, 1948

Major findings of operation: Benign prostatic hypertrophy

of autopsy: none, surgical

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion C. Sheely, M.D.
Address 1213 Light St Date signed 9/9/48

VS 150

Physicians: please write the causes of death clearly and legibly. Space for age is especially important.

Dr Reg 4-A 166347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 166747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 - 04 N. Lexington St.
(c) Hospital or institution: Aged Coloured Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lamprisse Hammond
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1874

8. AGE: Years	Months	Days	If less than one day
74	7	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER 12. Name Charles M. Hammond
13. Birthplace Unknown

MOTHER 14. Maiden Name Julia Johns
15. Birthplace Unknown

16 (a) Informant Mrs L. H. Read
(b) Address 1400-04 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Paul St.

SEP 12 1948 (a) (Date rec'd by registrar) (b) Huntington Ave. Baltimore Md. (Reg. district)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3-d 1948 to Sept 10 1948, and that I last saw h/m alive on Sept. 10 1948.

Immediate cause of death Cardio - Respiratory Failure — Duration

Due to Pulmonary Edema, acute

Due to Chronic arteriosclerotic Myocarditis

Other Conditions Coronary Insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M.D.
Address 4-E-33rd St -18 Date signed 9-11-48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hal 5 666748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666748

46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 West Chesapeake Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Trehearn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Seperated

6 (b) Name of ~~husband or~~ wife Edith Trehearn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-12-74

8. AGE: Years	Months	Days	If less than one day
73	9	12	22 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Calvin Trehearn
13. Birthplace Md

MOTHER
14. Maiden Name Marie Campbell
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Laurel Hill
Location Laurel Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

SEP 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1948 at 6.35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 9/10 1948 and that I last saw him alive on 9/9 1948.

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Due to Carcinoma of colon

Other Conditions Postoperative small bowel obstruction
(Include pregnancy within 3 months of death)

Date of operation August 27, 1948

Major findings of operation: Carcinoma of sigmoid colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard P. Griffith M.D.
Address Johns Hopkins Hospital Date signed 9/10/48

VS 150

AB-94159 G66749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66749 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Gibbons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 23- 1861

8. AGE: Years 83 | Months 10 | Days 14 17 | If less than one day hr. min.

9. Birthplace [illegible] Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Henry Gibbons
13. Birthplace [illegible] Pa.

MOTHER
14. Maiden Name Emma Fisher (D
15. Birthplace Pennsylvania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

SEP 12 1948 Tinsington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9-1 1948, at 3.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13- 1945 to 9-9- 1948, and that I last saw her alive on 9-9- 1948.

Immediate cause of death Pulmonary edema.

Due to Arteriosclerosis
Cardio-vascular Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kirkendall M.D.
Address Balto City Hosp. Date signed 11 Sept 48

VS 150

X

666750 ✓ 666750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 N. Bouth (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George James Smart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1897

8. AGE: Years	Months	Days	If less than one day
51	2	4	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation Laundryman

11. Industry or business St. Josephs Hospital

FATHER
12. Name Alexander Smart
13. Birthplace Canada

MOTHER
14. Maiden Name Alphonsine Pelkey
15. Birthplace Canada

16 (a) Informant Mrs Alphonsine Voight
(b) Address 1704 Dr Sota Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (a) SEP 12 1948 (b) Burlington Vermont (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/48 19 . at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D. Medical Examiner.
Date signed 9/10/48

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46 G667-51

G667-51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Loch Raven, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Loch Raven, Zone 4, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. KATHERINE SCALLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age (years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
65	—	18	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name Patrick J. Finn
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Princy
15. Birthplace Balto, Md.

16 (a) Informant Kathryn Parks
(b) Address Loch Raven Rd, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md

18 (a) Funeral director John Burns' Sons
(b) Address Merton E. Burns Towson, Maryland

(a) Date received by registrar SEP 12 1948 (b) Registrar Creighton Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948, to Sept 10 1948, and that I last saw her alive on Sept 10 1948.

Immediate cause of death Pseudopneumonia
Paralytic illeus with marked distention

Duration 4 days

Due to Carcinoma of Rectum

Due to Carcinomia of Rectum with metastasis

Duration 7 yrs (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation September 6, 1948

Major findings of operation: Carcinoma rectum with liver metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury?

23. Signature Kenneth M. Lineaweaver M. D.
Address Mercy Hospital Date signed 9-10-48

Please specify if important. Physicians: please write the causes of death clearly and legibly.

66752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 66752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 56
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Indiana (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 School St. (If rural give location)
(e) Citizen of foreign country? no Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hasinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 18 1931

8. AGE: Years 17 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Indiana, Pennsylvania (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Mark Hasinger
13. Birthplace Indiana, Pa.

MOTHER
14. Maiden Name Mae Young
15. Birthplace Pa.

16 (a) Informant Mr. Mark Hasinger (Father)
(b) Address 801 School St. - Indiana Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory St. Bernards
Location Indiana, Pa

18 (a) Funeral director W. J. Tickner & Sons
(b) Address North & Pa. Ave. - Balto. Md.

SEP 12 1948 (Date rec'd by registrar) Washington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948, at 11.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1948 to Sept 11 1948 and that I last saw him alive on Sept 11 1948.

Immediate cause of death: Acute Lymphatic Leukemia — Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] Jr
Address Mercy Hospital Date signed 9/12/48

VS 190

6667:53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

6667:53
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1838 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Katie L. Kestner

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	Female	White	Widowed

6 (b) Name of husband or wife C. William Kestner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1866

8. AGE: Years	Months	Days	If less than one day
82	3	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles M. Jackson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ann Fowler.
15. Birthplace Virginia.

16 (a) Informant Mr. F. C. H. Wessel
(b) Address 4206 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 12 1948 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 4:50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 9 1948, to Sept. 10 1948, and that I last saw her alive on Sept. 10 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp. Date signed 9/10/48

VS 150

66673-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Strathmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Strathmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva E. Holloway

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Holloway, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1875

8. AGE: Years 73 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Adam Schmidt

13. Birthplace Baltimore, Md.

14. Maiden Name Mary M. Grasbinder

15. Birthplace Baltimore, Md.

16. (a) Informant Mr. James Holloway

(b) Address 2402 Hamilton Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19. Filed SEP 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1948, at 2 o'clock A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert E. McClintock M.D.
Medical Examiner

Date signed 9-10-48

42

48-12238
666755

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666755 Registered No.

CERTIFICATE OF DEATH 242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pulaski & Fayette Sts
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 161 ½ Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA MAE BOWERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8-1948

8. AGE: Years 0 Months 1 Days 3 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond W. Bowers
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine O. Johnson
15. Birthplace Balto Md

16 (a) Informant Raymond W. Bowers
(b) Address 161 ½ Hollins St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof September 13-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminster Md

18 (a) Funeral director Poff & B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) SEP 13 1948 (Date received by registrar)
(b) Registrar's signature

SEP 13 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 11 1948. at 8-00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 29 1948 to 9 - 11 1948 and that I last saw h alive on 9-11-48 1948.

Immediate cause of death
Intract Hydrocephalus

Due to Brain Tumor
Extensive pyemia with

Due to multiple foci

Other Conditions C. P. C. Lungs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:
Brain

of autopsy: Brain Tumor Hydrocephalus

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature C. C. Fisher

Address Bon Secours Hosp Date signed 9-11

Duration
days

PHYSICIAN
Underline the cause to which death should be charged statistically

Correct age is especially important. Physicians, please write plainly.

(G)666756

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66756 5

Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Cooling Ave
(If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mr. Robert Ruskell Macgill

3 (b) If veteran, name war No

3 (c) Social Security Account No. 065-03-1396

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Mrs. Robert Ruskell Macgill

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1879

8. AGE: Years 69 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Balt. Co., Md.
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name William S. Macgill
13. Birthplace New York

MOTHER
14. Maiden Name Josephine McFaul
15. Birthplace Baltimore, Md.

16 (a) Informant Louisa R. Macgill (wife)
(b) Address 512 Cooling Ave

17 (a) Burial (Burial, cremation, or removal) **(b)** Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory Londontown
Location Baltimore

18 (a) Funeral director Sherwood & Sons Co.
(b) Address 1080 Mt. Ave.

19 (a) Filed SEP 13 1948 **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948 at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death Coronary occlusion — Duration 3 days

Due to Hypertensive cardio-vascular disease — 8+0 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

[redacted] Coronary occlusion
Hypertensive C-V Disease
of autopsy: Generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. E. Walter M. D.
Address Union Memorial Hosp. Date signed 9-9-48

SEP 13 1948

66675?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66675?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida County
(c) City or town Panama City -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 B. Victoria Circle
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Anban
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day: 44 hr. 9 min.
9. Birthplace Florida (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Anban -
13. Birthplace Mass. -

MOTHER
14. Maiden Name Thelma Rebburn
15. Birthplace Florida

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal)
(b) Date thereof 9/13/48 (month, day, year)
(c) Cemetery or crematory Pittsfield, Mass
Location Pittsfield Mass

18 (a) Funeral director John O Matchett & Son
(b) Address 1220 Eutaw St. Huntington Williamsport, Md

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 11a M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 11 1948 to Sept 12 1948 and that I last saw her alive on Sept 12 1948

Immediate cause of death: Respiratory paralysis.
Due to: cardiac failure
Due to: Congenital heart disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: Not yet complete

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature O.P. Hanson
Address Johns Hopkins Hospital Date signed 9/12/48

VS 150

666758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr Geo.
(c) City or town Rural - Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE RIDGELY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/10/[illegible]

8. AGE: Years 49 | Months 7 mo | Days 28 | If less than one day hr. min.

9. Birthplace Laurel, Pr. Geo Md.
(Town, county, and state)

10. Usual Occupation merchant

11. Industry or business general store

FATHER
12. Name Edward Wm.
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Leizear
15. Birthplace Md.

16 (a) Informant J. Robert Frothingham
(b) Address College Park, Md.

17 (a) Burial (b) Date thereof 9/15/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ivy Hill
Location Laurel

18 (a) Funeral director Dewitt Donaldson
(b) Address Laurel, Md.

19 (a) SEP 13 1948 (b) Huntington [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 9-12 1948, and that I last saw h[illegible] alive on 9-12 1948.

Immediate cause of death
Cardio-respiratory failure
Due to Arteriosclerosis
Due to Post operative
Other Conditions Pneumonia
Acute Nephritis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature W. A. Galambos M. D.
Address Mercy Hosp Date signed 9-12-48

VS 15

X

66759
A 63207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-5E

66759
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL, and give town)
(d) Street No. 18 E Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence Tyeryar -
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-96

8. ACE: Years 11 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Chas. Tyeryar
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Boone
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick - Md.

18 (a) Funeral director C. E. Cline & Son
(b) Address Frederick - Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5th 1948 to Sept 12 1948 and that I last saw him alive on Sept 12 1948

Immediate cause of death: Streptococcus Pneumonia — Duration

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature C. E. Stephan M. D.
Address Date signed

VS 150

666760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 666760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1740 h. Gay Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1740 h Gay Street (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Cora V Sproul

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alfred R Sproul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-1891

8. AGE: Years 57 Months 4 Days 7 If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mose Kay

FATHER 13. Birthplace Washington D.C

MOTHER 14. Maiden Name Jane Walker

MOTHER 15. Birthplace Washington D.C.

16 (a) Informant Alfred R. Sproul

16 (b) Address 1740 h Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)

17 (c) Cemetery or crematory Baltimore Cemetery

Location North Ave & Rose St

18 (a) Funeral director Albert L Stitely

18 (b) Address 1106 h Chester Street

19 (a) SEP 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8 1948, to Sept 10 1948, and that I last saw h alive on Sept 10 1948.

Immediate cause of death: Bronchial Tuberculosis — Duration

Due to

Due to

Other Conditions Chronic Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 1823 N. Market St. Date signed 9-10-48

VS 150

666761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Schroeder Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willis GALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dora Gale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 10, 1915

8. AGE: Years 33 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace: Maryland md
(Town, county, and state)

10. Usual Occupation: Oyster - Shucker

11. Industry or business

FATHER
12. Name: William Gail
13. Birthplace: Maryland md

MOTHER
14. Maiden Name: Florence Adams
15. Birthplace: Maryland, md

16 (a) Informant: Dora Gale
(b) Address: 103 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 13, 1948 (month, day, year)

(c) Cemetery or crematory: Princess Anne
Location: Maryland

18 (a) Funeral director: Mrs Katie R Williams

(b) Address: 32[illegible]

19 SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1948 at 10:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature: George A. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

666762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 666762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Sunlight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Louise Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John N Abbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (c) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Isabella Abbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1864

8. AGE: Years 84 | Months 2 | Days 18 | If less than one day hr. min. 16

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Bethlehem Steel (Retired)

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Albert Aschemeier
(b) Address 2912 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948 at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to 19 ; and that I last saw h alive on 9/10 1948.

Immediate cause of death Suspected cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Trougott

Address 1623 E N Ave Date signed 9/10/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156 B

Registered No. 666763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Stockton St. (If rural give location) 1316
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Elizabeth Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1941

8. AGE: Years	Months	Days	If less than one day
7			hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Carter
13. Birthplace Frederick Md

MOTHER
14. Maiden Name Addie Wade.
15. Birthplace Frederick Md.

16 (a) Informant Addie Wade Smith
(b) Address 1613 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 SEP 13 1948 (Date rec'd by Registrar) [illegible] for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948 at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1948 to 9-9 1948 and that I last saw her alive on 9-9 1948

Immediate cause of death Dermatomyositis

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Hardin Jr. M. D.
Address Univ. Hosp. Date signed 9-11-48

VS. 150

X

866764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. 866764

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Ruxton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ZELDA Jennie Tralins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name Deborah
15. Birthplace Russia

16 (a) Informant Samuel Tralins
(b) Address 1803 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Dolfield Road

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2109 Eutaw Place

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948 at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1948 to 9/12 1948
and that I last saw her alive on 9/12 1948

Immediate cause of death: Chronic & Subacute Hepatitis — Duration 6 Mo.

Due to: Common Bile Duct Obstruction — 6 Mo.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation MAY 17, 1948

Major findings of operation: Common Bile Duct Obstruction.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward S. Kaelin M.D.
Address 1847 W. North Ave Date signed 9/12/48

VS 150

666765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. 666765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 S. Willard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 S. Willard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Popp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank C. Popp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	29	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Szeck
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Evelyn Brown daughter
(b) Address 4 S. Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 48 (month) (day) (year)
(c) Cemetery or crematory Mendowridge
Location Dorsey, Md

18 (a) Funeral director Harry A. Wright
(b) Address 4101 Edmondson Ave

19 SEP 13 1948 (Date rec'd by registrar) Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Sept. 10 1948, and that I last saw her alive on Sept. 10 1948

Immediate cause of death: Inoperable carcinoma of uterus and extensive involvement of adnexa — Duration: 4 Yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Brown

Address 116 Oakdale Rd Date signed 9/11/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

066766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 066766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5202 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ?
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5202 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Frederick Bartell

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-18-8123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Ruth ~~Garrett~~ Bartell
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1893

8. AGE: Years	Months	Days	If less than one day
55	-	21	hr. min.

9. Birthplace McDonogh, Md. (Town, county, and state)

10. Usual Occupation Lithographer Engraver

11. Industry or business Dept. of Interior, U.S. Govt

FATHER
12. Name Frantz Herman Bartell
13. Birthplace Berlin, Germany

MOTHER
14. Maiden Name Ellen Jane Redding
15. Birthplace Manchester, Carroll Co., Md.

16 (a) Informant Mrs. Margaret Ruth Bartell
(b) Address 5202 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miller Guiornan
(b) Address 4510 Liberty Heights Ave.

19 (a) SEP 13 1948 **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 9/11/48, and that I last saw him alive on 9/4/48 19

Immediate cause of death
1 Coronary Occlusion
Due to cardio vascular renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 hr.
15 yrs?

Date of operation None
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harper M. D.
Address 5201 Gwynn Oak Ave Date signed 9/12/48

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666767

JL - 122798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. 666767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Aval
(c) Hospital or institution:
Baltimore City Hospitals. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dorn

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mamie M. Dorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1877

8. AGE: Years 70 | Months 11 | Days 24 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto. City

FATHER
12. Name John Dorn
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ? ---
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 4.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1948 to Sept 10 1948, and that I last saw h im alive on Sept. 10 1948.

Immediate cause of death Uremia — Duration 5 days

Due to Bilat pyelonephritis — mos

Due to C B Q Nodes — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/3/47

Major findings of operation: C B Q Nodes metastases

of autopsy: bilat pyelonephritis, uremia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M D
Address Balt City Hosp Date signed 9/14/48

VS 150

G66768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

801

Registered No. G66768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2110 ALLENDALE RD~~
(c) Hospital or institution: MARYLAND GEN. HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 ALLENDALE RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME NORMAN F. DEWLING

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-26-9101

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 10 1929

8. AGE: Years 19 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business Cornell College

FATHER
12. Name WALTER F. DEWLING
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY NORMAN
15. Birthplace NEW YORK

16 (a) Informant MOTHER & FATHER
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Tuntungton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 SEPT 1948 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 SEPT 1948 to 11 SEPT 1948. and that I last saw h/M alive on 11 SEPT 1948

	Duration
Immediate cause of death CARDIO-RESPIRATORY FAILURE	
Due to DIFFUSE ENCEPHALOMYELITIS	22 days
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

Gross or autopsy: SWELLING & DISCOLORATION OF UPPER DORSAL CORD

PHYSICIAN
Underline the cause to which death should be charged as satisfactorily

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald F. England M. D.
Address Maryland Gen Hosp Date signed 11 Sept 48

VS 159

666769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

Registered No. 666769

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway & Fairmount

(c) Hospital or institution Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5309 Ready ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary B. Chambers

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George T. Chambers

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1875

8. AGE: Years 73 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Md. (Frederalsburg) (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Robert Bradley

13. Birthplace Md.

14. Maiden Name Mary Noble

15. Birthplace Md.

16 (a) Informant Mr. George T. Chambers, husband

(b) Address 5309 Ready Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)

(c) Cemetery or crematory Hill Crest Cem.

Location Federalsburg, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Wm. J. Tickner, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 / 12 1948 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 9/12 1948 and that I last saw her alive on 9/12 1948.

Immediate cause of death Cardiac failure - Cerebral vascular accident

Due to DUE TO - Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. D. Munter

Address Church Home Date signed 9/12/48 M.D.

VS 153

Correct age in capitals important. Physicians: please write the causes of death clearly and legibly.

666770
473888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 666770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9 E

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3703 Spalding, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Haefner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Bertha M. Haefner

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 4-9-77

8. AGE: Years	Months	Days	If less than one day
71	5	3	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name August Haefner
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Strube
15 Birthplace [redacted] Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Headowridge
Location Howard Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 13 1948 (Date filed by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948 at 2.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1948 to 9-12- 1948 and that I last saw him alive on 9-12- 1948

Immediate cause of death Laryngeal edema post operation

Due to Carcinoma face & neck glands

Due to

Other Conditions Diabetes, cirrhosis (Include pregnancy within 3 months of death)

Date of operation Sept 10, 48

Major findings of operation: Squamous carc. face, neck metastasis

of autopsy Laryngeal edema

Duration
6 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. Handelsman M.D.
Address The Johns Hopkins Hospital Date signed 9-12-48

VS 130

G66771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G66771

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hosp. Asc. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 264 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1844 W Pratt St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edwin B. HUGGINS

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-22-1801

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Mattie Wilson Huggins

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JUNE 21-1874

8. AGE: Years	Months	Days	If less than one day
74	2	20	____ hr. ____ min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George D. Huggins

13. Birthplace New Jersey

MOTHER

14. Maiden Name Mary Goff

15. Birthplace New Jersey

16 (a) Informant: Mrs Margaret L. Rose

(b) Address 1519 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-1948 (month) (day) (year)

(c) Cemetery or crematory London Park,

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.

(b) Address North & Penna Aves Baltimore, Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Tentative Number [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/11 1948

and that I last saw h alive on 9/11 1948

Immediate cause of death Acute peritonitis — Duration

Due to Metastatic lesions

Due to Cancer of neck

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph L. Aronite

Address Mercy Date signed 9/11/48

VS 150

66772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. 66772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Ferndale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WAYSON D. GERWIG

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 220-14-3244

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Beulah Gerwig

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1924

8. AGE: Years: 24 | Months: 2 | Days: 29 | If less than one day: hr. min

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: -

11. Industry or Business

FATHER
12. Name: Jacob F. Gerwig
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mabel Downs
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Jacob F. Gerwig, Jr.
(b) Address: 4111 Newton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948 at 4:50 AM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gun-shot wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at ? A. M.
(b) Where did injury occur? 3015 Ferndale Avenue
(c) Did injury occur at home, on farm, (Address) place, in public place? Home While at work? No
(d) Means of injury: Firearms

23. Signature: Howard J. Madden M.D. Medical Examiner.
Date signed 9-11-48

VS 151

666773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ALVERDA G. LaMOTTE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If Alive, give age years

7. Birth date of deceased: mo., day, yr Oct. 13, 1863

8. AGE: Years 84 | Months 10 | Days 27 | If less than one day: hr. min.

9. Birthplace Finksburg, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Lewis A. J. LaMotte
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Alice H. Stocksdale
15. Birthplace Carroll Co., Md.

16 (a) Informant Dr. W. O. LaMotte, Brother
16 (b) Address Wilmington, Del.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
17 (c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
18 (b) Address Balto., Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Tinting for Photocopy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1948, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1948, to Sept 10 1948, and that I last saw her alive on Sept 10 1948.

Immediate cause of death: Lobar Pneumonia — Duration: 2.

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2604 Garrison Blvd Date signed 9-13-48.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

G86774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G86774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 O'Donnell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Bell Kiefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife: August Kiefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1876

8. AGE: Years 71 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Henshaw
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Ford
15. Birthplace Anne Arundel County

16 (a) Informant Mrs. Wm. Mack
(b) Address 3308 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 13-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 4.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to Sept 8 1948
and that I last saw her alive on Sept 7 1948

Immediate cause of death: Coronary Occlus. — Duration 1/2 hr.
Due to: Arteriosclerosis. — 1 year
Due to: Hypertension.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 3605 Belair Rd Date signed Sep. 11/48

VS 150

066775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 066775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 Patterson Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto-5 (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Ins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A Kralick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis A. Kralick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12 - 1887

8. AGE: Years 61 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Louis Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Margaritta P. Bertsch

15. Birthplace Germany

16 (a) Informant Ruther M. Kralick

(b) Address 905 Ins. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-48 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave. & Gay St.

18 (a) Funeral director John L. Miller

(b) Address 2334 Jefferson St.

SEP 13 1948 (Date rec'd by registrar)

(b) [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon (Autopsy / Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J Kelbick M.D. (Medical Examiner)

Date signed Sept 10, 1948

VS 181

66776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3336 Lyndale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Lyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. ~~Wall~~ Wall

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-5856

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Bessie Wall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1882

8. AGE: Years	Months	Days	If less than one day
66	6	21	15 hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired.

FATHER
12. Name Olin Wall
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sophia Fairbank
15. Birthplace Baltimore Md

16 (a) Informant Mrs Bessie Wall
(b) Address 3336 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Powell
(b) Address 2727 Edmondson Ave Funeral for Baltimore, Md.

19 (a) 9-12-1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 9-11 1945 and that I last saw him alive on 9-10 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 yrs.
Due to Generalized Arteriosclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 9/13/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66677

66777

95B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 W Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise G. McKinley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. James M. McKinley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1912

8. AGE: Years 35 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Taneytown, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph E. Classon
13. Birthplace Taneytown, Md.

MOTHER 14. Maiden Name Mary Louise Haus
15 Birthplace Baltimore, Md.

16 (a) Informant James M. McKinley
(b) Address 217 W. Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director H. A. Ulman and Son
(b) Address 805 N Calvert St.

19 (a) SEP 13 1948 (Date filed by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1948 at 2:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2:14 P.M. to 2:19 P.M., Sept 11 1948 and that I last saw her alive on Sept. 11, 1948.

	Duration
Immediate cause of death Cerebral embolism	
Due to Rheumatic heart disease	8 yrs.
Due to Bacterial Endocarditis	3 wks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hosp Date signed Sept 11, 48

VS 153

G66778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Bethel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1874

8. AGE: Years	Months	Days	If less than one day
74	8	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Edward St. Jones

13. Birthplace Md.

MOTHER 14. Maiden Name Annie E. Caldwell

15. Birthplace Md.

16 (a) Informant Zenobia Hollis

(b) Address 2502 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus Md.

18 (a) Funeral director Mr. C. H. A. Elliott Dupler

(b) Address 618 N. Carrollton Ave.

19 SEP 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 9 1948, and that I last saw him alive on Sept 8 1948.

Immediate cause of death	Duration
Myocarditis	?
Generalized arteri-Sclerosis	?
Due to	
Due to	
Other Conditions - (Include pregnancy within 3 months of death)	

Date of operation -

Major findings of operation: -

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Thom M. D.

Address 1202 N Carrollton Ave Date signed Sept 13 1948

VS 15

666779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. 666779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Bonaparte Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or ~~town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Bonaparte Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis J. Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Margaret M. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1889

8. AGE: Years	Months	Days	If less than one day
59	5	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Agent
11. Industry or business Life Insurance

FATHER
12. Name John C. Murray
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth McDermott
15. Birthplace Balto. Md.

16 (a) Informant Mrs Margaret M. Murray
(b) Address 1004 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street, Md.

19 SEP 12 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 7:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1945 to 9/11 1948 and that I last saw him alive on Sept 11, 1948.

Immediate cause of death Carcinoma of bladder — Duration 1 year

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation Aug 21 - 1948

Major findings of operation Confirmed transitional cell carcinoma of bladder extension through entire wall

Findings of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 9/11/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Covington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Covington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Barrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Catherine Barrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1853

8. AGE: Years abt. 64 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Barrett
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Vincent J. Barrett
(b) Address 1727 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 19 48, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogers M.D.
Medical Examiner
Date signed 12 Sept 48

066781 - 122342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

Registered No. 066781

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 25, 1910

8. AGE: Years 37 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Thompson
13. Birthplace S. C.

MOTHER
14. Maiden Name Minnie Robinson
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15. 1948 (month) (day) (year)
(c) Cemetery or crematory Spartanburg. Sc a Cem.
Location Spartanburg. SC.

18 (a) Funeral director Elroy. O. Wilson
(b) Address 1000. Brently. Ave.

19 (a) SEP 13 1948 (b) Huntingdon Pennsylvania, Md
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH Sept. 11, 1948, at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1948, to Sept. 11 1948, and that I last saw h im alive on Sept. 11 1948.

Immediate cause of death For advanced bilateral pulmonary tuberculosis with cavities — Duration 6 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 9-12-48

VS 150

66782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 66782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Pk. Apts. Beech ave (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Kathryn (Jones) Bradley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James Bradley (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1885

8. AGE: Years 63 | Months 6 | Days 28 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation — housewife

11. Industry or business —

FATHER 12. Name Steven Pambrill

13. Birthplace Ellicott City, Md.

MOTHER 14. Maiden Name Kate Gorman

15. Birthplace Howard Co, Md.

16 (a) Informant James Bradley Jr.
(b) Address Wyman Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

SEP 14 1948 (Date rec'd by registrar) Huntingtown, Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948 to 9-12 1948 and that I last saw her alive on 9-8 1948.

Immediate cause of death Uremia — Duration

Due to Hypertensive cardiovascular disease

Due to —

Other Conditions Left hemiplegia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John R. Smith, Jr. M. D.
Address Union Mem. Hosp. Date signed 9/12/48

VS 153

6783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 666783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. M.
(c) City or town Ridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lucy E. Trimble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1891

8. AGE: Years	Months	Days	If less than one day
57	8	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles Holbrunner
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Connick
15. Birthplace Md.

16 (a) Informant Admission Card.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Jonestown, Md
Location Jonestown, Md

18 (a) Funeral director W. C. Mattingly & Son
(b) Address Jonestown, Md

19 SEP 14 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 19 48 at 11 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 19 48 to 9-13 19 48.
and that I last saw her alive on 9-13 19 48.

Immediate cause of death
Cardiac failure
Due to [redacted]
Left vent. Strain
Due to
Other Conditions Portal Cirrhosis
(Include pregnancy within 3 months of death)
Date of operation 8-28-48
Major findings of operation: Ascites
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Powell M.D.
Address Mercy Hosp Date signed 9-15-48

95c

66784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

Registered No. 66784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 N. Pulaski Street
(c) Hospital or institution: 20-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Pulaski Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Linton Lane

3 (b) If veteran, name war None

3 (c) Social Security Account No. 226-14-4860

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie T. Lane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30 1888

8. AGE: Years 60 Months 7 Days 13 If less than one day hr. min.

9. Birthplace Berkely Virginia
(Town, county, and state)

10. Usual Occupation Sander

11. Industry or business International Elec. Co

FATHER
12. Name Thomas Lane
13. Birthplace Virginia

MOTHER
14. Maiden Name Lela Haskett
15. Birthplace Virginia

16 (a) Informant Mrs. Nellie T. Lane
(b) Address 313 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George L. Schwab.
(b) Address 1101 Frederick Avenue

19 SEP 14 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Sept 12 1948. and that I last saw him alive on Sept 12 1948.

Immediate cause of death (Coronary Thrombosis

Due to Arteriosclerotic Cardiac disease

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Duration 1 month

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Pulaski M. D.
Address 195 N Bath St Date signed 9/13/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 199

666785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

666785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Bal. Co.
(c) City or town [redacted] Glenburnie
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 6th ave N. [redacted] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Grisbert.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Irene.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1874

8. AGE: Years 73 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Printer
11. Industry or business Lum Paper

FATHER
12. Name Richard (died)
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Susan Hann.
15. Birthplace Frederick Co Md (died)

16 (a) Informant Mrs. Irene Husband
(b) Address Glen Burnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEPT. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thomas W. Tighe
(b) Address Glen Burnie, Md.

19 SEP 14 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948, to 9-12 1948, and that I last saw him alive on 9-12 1948.

Immediate cause of death Cardiac failure

Due to Perforated gastric ulcer

Duration

Other Conditions Arteriosclerotic cardiovascular disease & grade III chronic
Ca of lung & massive pleural effusion & metastasis to pleura

Date of operation

Major findings of operation: None

of autopsy: As a layman

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney J. Vendle, Jr. M.D.
Address St. Agnes Hospital Date signed 9-12

VS 153

117a

65786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 7236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 Prestman St.
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Prestman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Buckner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife James Buckner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1881

8. AGE: Years 67 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Greenville, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Buckner
13. Birthplace Greenville, Va

MOTHER
14. Maiden Name Lottie Smith
15. Birthplace Greenville, Va

16 (a) Informant Mary Lomax
(b) Address 305 Presdman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Warrenton Va
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroder St

SEP 14 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Sept 11 1948 and that I last saw h[illegible] alive on Sept 10 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Malig. Hypertension & arterio sclerosis	
Due to	
Other Conditions Hypertension & arteric heart disease (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Sept 13 1948

VS 150

52E

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66787

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Ruxton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX I. GOLDFOSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 187?

8. AGE: Years 75 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Bert Goydon

(b) Address 1050 N Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month)

(c) Cemetery or crematory Hebrew Friendship Cem

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

SEP 14 1948 (Date rec'd by registrar) Baltimore, Md.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 12 1948 at 6:30 M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)

(d) Means of injury

23. Signature Medical Examiner M.D.

Date signed 9/13/48

VS 151

666788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 666788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp 17 DBA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State 2d (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Fremont (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Sheldon Jones

3 (b) If veteran, name war / War 1

3 (c) Social Security Account No. Sample

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 10 | Months | Days | If less than one day Hr. min.

9. Birthplace Burgaw. N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Hoeley Jones
13. Birthplace N.C.

MOTHER 14. Maiden Name Annie Murphy
15. Birthplace N.C.

16 (a) Informant: Charles Jones
(b) Address 601 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-48 (month) (day) (year)
(c) Cemetery or crematory Burgaw. N.C.
Location

18 (a) Funeral director James Asbury
(b) Address 1142 Wolfe St.

19 SEP 14 1948 (Date rec'd by registrar) (b) Hunting to Indiana, Pa

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1948 at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 Sept 48 at 12:30 A.M.
(b) Where did injury occur? 1127 S. Chapel St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public (While at work) No
(d) Means of injury Shot

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 12 Sept 48

VS 151

X

66789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. 66789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 E. Hamburg St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosena Appell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1886

8. AGE: Years 61 | Months 11 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Charles H. Appell
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hudson
15. Birthplace Md

16 (a) Informant Gertrude V. Appell
(b) Address 303 E. Hamburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director John F. Henny Inc.
(b) Address 746 Light St.

19 (Date rec'd by Registrar) (Registrar) (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Sept 11 1948 and that I last saw h[illegible] alive on Sept 11 1948

Immediate cause of death: acute pulmonary oedema — Duration: 3 days
Due to: chronic myocarditis, 1 year
Due to: senility arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1224 Mulberry St (Date signed) 9/13/48

VS 150

× 9/13/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66790 — 937 — Registered No. 16250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County QUEEN ANNE'S
(c) City or town Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Grasonville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Coursey
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Lilly Coursey
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) July 18-1869
8. AGE: Years 79 Months Days 25 If less than one day hr. min.
9. Birthplace Grasonville Md. (Town, county, and state)
10. Usual Occupation Oyster dredger
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Madge Lechner
(b) Address 2519 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd.

18 (a) Funeral director Chance Funeral Home
(b) Address 216 W. Chase St

19 SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12- 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1948 to 9-12- 1948, and that I last saw him alive on 9-12- 1948

Immediate cause of death Chronic myocardial disease — Duration 3 years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Mora M. D.
Address 448 N. Eutaw ave Date signed 9-13-48

VS 180

X

Please write plainly with pen and INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~MARYLAND GEN~~ 17
(c) Hospital or institution:
MARYLAND GENERAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 HOURS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. PACA ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME OLIVAR BELLAMY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	NEGRO	MARRIED

6 (b) Name of husband or wife Rena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1901

8. AGE: Years	Months	Days	If less than one day
46	9		hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation CEMENT WORKER
11. Industry or business

FATHER
12. Name Jack Bellamy
13. Birthplace N.C.

MOTHER
14. Maiden Name Lurvinia ?
15. Birthplace S.C.

16 (a) Informant WIFE Rena Bellamy
(b) Address 527 N. Paca St.

17 (a) [illegible] (b) Date thereof 9-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Woodlawn N.C.

18 (a) Funeral director A. Halstead
(b) Address 918 Mount Hill Ave.

SEP 14 1948
(Date rec'd by registrar) [illegible]

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 SEPT 1948, at 6:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2:30 PM to 6:35 PM 12 SEPT 1948.
and that I last saw him alive on 12 Sept 1948.

Immediate cause of death	Duration
PULMONARY EDEMA	4 HOURS
Due to HYPERTENSIVE CARDIO VASCULAR DISEASE	Few YEARS
~~Due to~~ WITH A CEREBRAL HEMORRHAGE	6½ hours
~~Other Conditions~~ AND ACUTE CONGESTIVE CARDIAC FAILURE	4 hours

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation:
of autopsy Pulmonary edema Cardiac hypertrophy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald L England M D
Address Maryland General Hosp Date signed 12 Sept 48

66792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 66792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Wildwood Beach, Baltimore #21, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Gertrude E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8-1883

8. AGE: Years: 65 | Months: 1 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Fish Dealer

11. Industry or business

FATHER
12. Name: Benj. David Pierce
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Mary B. Frederick
15. Birthplace: Md.

16 (a) Informant: Mrs. Gertrude Pierce
(b) Address: Wildwood Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave Rd

18 (a) Funeral director: John B. Connelly
(b) Address: 418 Eastern Ave.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/11 1948, and that I last saw him alive on 9/11 1948.

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day

Due to: Bronchogenic carcinoma, right lung — 6 months

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Alfred N. Dann, M.D.

Address: Maryland Gen'l Hosp. Date signed 9/11/48

VS 150

Check age if especially important. Physicians: please write the causes of death clearly and legibly.

66793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. Dukeland st.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~life~~ 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 South Savage St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Horhoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Horhoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1896

8. AGE: Years	Months	Days	If less than one day
52	7	28	hr. min.

9. Birthplace Romania
(Town, county, and state)
10. Usual Occupation Loader, Bethlehem S/Co
11. Industry or business

FATHER
12. Name Geo. Horhoe
13. Birthplace Romania

MOTHER
14. Maiden Name Unk
15. Birthplace "

16 (a) Informant Mrs. Anna Horhoe
(b) Address 611 Savage St

17 (a) Burial (b) Date thereof Sept 15-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Crest
Location Connell Mill Rd

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave

19 (a) SEP 14 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948, at 6 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948, to 8/12 1948 and that I last saw h[illegible] alive on 8/11 1948.

Immediate cause of death Malignant Melanoma, source undetermined — Duration Several months

Due to

Due to

Other Conditions Horshoe Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: /

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice W. Davis M. D.
Address W. Balt. Gen. Hosp. Date signed 9-12-48

VS 150

Maurice W. Davis

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666794

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666794 Registered No.

CERTIFICATE OF DEATH 81a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3253 E. Baltimore St.
(c) Hospital or institution: Sydenham Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3253 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Raymond Libby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/1940

8. AGE: Years	Months	Days	If less than one day
7	10	22	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Edward Libby
13. Birthplace Eugene Oregon

MOTHER
14. Maiden Name Helen Capet
15. Birthplace St. Augustine, Fla.

16 (a) Informant Mother
(b) Address 3253 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John A. Hasan
(b) Address 3600 E. Baltimore St

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Remington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 9 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1948 to 9/11 1948 and that I last saw him alive on 9/11 1948.

Immediate cause of death Pneumococcal Meningitis — Duration 1 day.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Goldstein
Address Sydenham Hosp. Date signed 9/10

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

666795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 126
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Clinton Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. George Henry Yaekel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married~~, ~~widowed~~, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-76

8. AGE: Years 72 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Sold Papers

11. Industry or business

FATHER 12. Name Conrad Yaekel

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Singer

15. Birthplace Germany

16 (a) Informant Mrs. Gokes Stafford

(b) Address 818 Eutaw Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John C. Moran

(b) Address 3600 Baltimore St

19 SEP 14 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/48 1948 at 8:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1948 to 9/12 1948 and that I last saw him alive on 9/12 1948.

Immediate cause of death Cardio Respiratory Failure

Due to Hepatic Cirrhosis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Evans M. D.

Address St. Joseph's Hosp Date signed 9/12/48

66796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 666796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Druid Hill Ave
(c) Hospital or institution: 14-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2215 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JARRETT Edwards MILLER

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/2/1928

8. AGE: Years	Months	Days	If less than one day
20	2	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Newspaper Agent

11. Industry or business

FATHER 12. Name Samuel Miller
13. Birthplace Towson, Md.

MOTHER 14. Maiden Name Coryethia B. Bell
15. Birthplace Baltimore, Md.

16 (a) Informant Coryethia M.S. Mason
(b) Address 2215 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ann Arundel County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/48 19 , at 5:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1948 to 9/10 1948 and that I last saw h[illegible] alive on 9-10 1948.

Immediate cause of death: Broncho-pneumonia — Duration: 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 EAST MADISON ST. BALTIMORE 5, MD.
Date signed 9/13/48

566797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. 566797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 S. Charles St.
(c) Hospital or institution: 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1807 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence C. Clark.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/1900

8. AGE: Years 47 | Months 10 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Middleton L. King
13. Birthplace Md.

MOTHER
14. Maiden Name Sara E. King
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same.

17 (a) B. (Burial, cremation, or removal) **(b) Date thereof** 9-15-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3 Pos. Frederick Rd

18 (a) Funeral director Jas. L. Wheeler
(b) Address 430 S. Fort Ave.

SEP 14 1948 (Date rec'd by registrar) **(d)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1948 to Sept 12 1948; and that I last saw h[illegible] alive on Sept 12 1948.

Immediate cause of death Myocardial Insufficiency

Due to

Due to Malignancy

Other Conditions Chronic Nephritis
Osteomalacia
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Schreuer
Address 1337 S. Charles St. **Date signed** 9/13/48 M. D.

VS 150

93E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 H

Registered No. 66798

66798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Washburn Ave
(c) Hospital or institution: 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Washburn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Marshall

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8511

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced, M.

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/1883.

8. AGE: Years 65 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Water Dept
11. Industry or business Con. Of. Co.

FATHER 12. Name Joseph W.
13. Birthplace Md.

MOTHER 14. Maiden Name Rosa Byers.
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McKenney
(b) Address 803 Fort Ave.

19 SEP 14 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/12 1948 and that I last saw deceased alive on 9/11/48 1948

Immediate cause of death Coronary thrombosis

Due to Arteriosclerosis

Due to Enlarged prostate with chronic kidney infection

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Duration: one year

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Stevens Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Samuel Rubin

66799
444428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. 66799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL, and give town)
(d) Street No. 132 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife James Lewis

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr) 2-24-22

8. AGE: Years	Months	Days	If less than one day
26	6	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Newman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Hannah Grimes
15 Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph S. Lords, Jr.
(b) Address 1304 N. Central Ave

19 (a) SEP 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 12 - 1948 at 5 - 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1948 to 9-12- 1948 and that I last saw her alive on 9-12- 1948

Immediate cause of death Carcinoma of Cervix — Duration

Due to Vaginal Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 30 1948

Major findings of operation: Carcinoma Terminal & radiation necrosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature John Watt Jr.
Address Johns Hopkins Hosp. Date signed Sept 12

VS 150

66800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1360 Washington Blvd.
(c) Hospital or institution 21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1360 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMER ADELLA HEINER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Jacob Heiner

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1869

8. AGE: Years 79 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George J. Hasfrouss
13. Birthplace: France

MOTHER
14. Maiden Name: Emma S. Longley
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. John J. Heiner, husband
(b) Address: 1360 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1940 to Sept 12 1948 and that I last saw him alive on Sept 12 1948

Immediate cause of death: Acute Heart Failure — Duration: 1 day

Due to: Coronary Sclerosis — 6 months

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis J. Gaynor M. D.
Address 716 Wolfe St (716 WASH. BLVD.) (Date signed) 9/13/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66804 C - 86047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rollins Mary Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27. 1853

8. AGE: Years	Months	Days	If less than one day
94	10	17	hr. min.

9. Birthplace Gettysburg, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Washington Bowen
13. Birthplace Pa. (Gettysburg)

MOTHER
14. Maiden Name Lucy Ann Van Orsdel
15. Birthplace Littlestown Pa.

16 (a) Informant B. C. H. Records
(b) Address 1940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem.
Location Gettysburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 14 1948 (Date rec'd by Registrar) (b)

VS 55

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 10.05 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 18 1944 to Sept. 13 1948. and that I last saw her alive on Sept. 13 1948

Immediate cause of death Bronchopneumonia — Duration 4d.

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Nelson
Address BCH Date signed 9/13/48

666802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 666802

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. EMORY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife: Albertina Emory.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 21. 1870

8. AGE: Years	Months	Days	If less than one day
78	3	22	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Foreign Merchant
11. Industry or business Self.

FATHER
12. Name John K. Emory.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Md.

16 (a) Informant Mrs. Robert Jones.
(b) Address 2133 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

SEP 14 1948 (b) Huntington Maryland
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1948 at 10.15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to Sept. 12 1948; and that I last saw him alive on Sept. 12 1948.

Immediate cause of death	Duration
Pneumonia, Lobar.	2 days.
Due to Cerebro Sclerosis	?
Due to Arterio Sclerotic C. V. Disease.	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel C. Bozorad M. D.
Address 1905 W. Baltimore St. Date signed 9/14/48

66803 ES-122882

CERTIFICATE CORRECTED 9-1-50 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 666803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Boehm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: D.

6 (b) Name of husband or wife: Alice Boehm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1883

8. AGE: Years 64 (65) 64 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Henry Boehm
13. Birthplace: Germany

MOTHER
14. Maiden Name: Josephine Christ
15. Birthplace: Germany

16 (a) Informant: RECORDS- Balto. City Hospitals
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/16/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md.

18 (a) Funeral director: Fulton & Son
(b) Address: 1217 W. Fayette St.

SEP 14 1948 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-48, 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-36, 1936, to 9-12, 1948, and that I last saw him alive on 9-12-, 1948.

Immediate cause of death (a) Fulbar carcinoma bilateral tuberculosis & cavitation (over)
Duration: years -

Duration (b) 2 mo Carcinomatosis liver & primary site probably rectum
Duration (c) Adenocarcinoma of stomach (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Warren E. Porter
Address: Balto. City Hospitals Date signed: 9/13/48 M. D.

G66804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G66804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~701 E. Melville Ave.~~
(c) Hospital or institution: Mercy Hospital Balto md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto #18, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 E. Melville Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bleach.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-3238

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Lottie Bleach.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1873.

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	11	6		

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation Watchman.
11. Industry or business Coal Sq. Brewing.

FATHER
12. Name John. Bleach.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Herwig
15. Birthplace Germany

16 (a) Informant Lottie Bleach
(b) Address 701 E. Melville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave - Local

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 14 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948, to Sept 12 1948, and that I last saw him alive on Sept 12 1948:

Immediate cause of death	Duration
Cerebro-vascular Accident - probably cerebral thrombosis.	4 days
Due to	
Due to	
Other Conditions Carcinoma of Large Bowel - possible (Include pregnancy within 3 months of death)	2 yrs.

Date of operation None
Major findings of operation:
of autopsy: Hypernephroma left kidney Metastases.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Brueser M. D.
Address Mercy Hospital Date signed 9/13/48

VS 150

83a

66805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 66805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Third st. Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wehgartner (JOSEPH WEHGARTNER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-0606

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18th 1886

8. AGE: Years 62 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Watchman - Guard

11. Industry or business Jones Distillery

FATHER
12. Name (Not Known) Wehgartner
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Dorothea Kozzybski
(b) 3515 Third st - Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month)
(c) Cemetery ~~or crematory~~ Holy Cross
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra cranial Hemorrhage

Due to

Other Conditions Hemorrhage A.S.C.V.D. Diabetes -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9 Sept 48 2 P. M. 26/6
(b) Where did injury occur? Walter's Crossing Co's Waiting station (Canton) (Factory, Mine, farm, street, etc.)
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? No
(d) Means of injury Struck by #26 Streetcar

23. Signature Edward V. Rogan M.D.
Medical Examiner
Date signed 12 Sept 48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 85

Registered No. 666806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Edmondson Ave.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BERKLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1932

8. AGE: Years	Months	Days	If less than one day: hr.	min.
16	6	2		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John J. Berkley, Sr.
13. Birthplace Lousville, Kentucky

MOTHER
14. Maiden Name Viola King Brkley
15. Birthplace Montgomery Co., Md.

16 (a) Informant Viola Berkley
(b) Address 1527 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Sirocco St. Washington Heights, Md.

19 (a) 14 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 10 1948, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions Epilepsy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer J. Thurston M.D.
Medical Examiner.
Date signed 9/20/48

VS 151

1113

G66807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G66807

Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Pulaski Street
(c) Hospital or institution: ********** 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH R. BROWN

3 (b) If veteran, name war ********

3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JAMES H. BROWN
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) JUNE 16- 1873

8. AGE: Years	Months	Days	If less than one day
75	2	27 26	********** min.

9. Birthplace QUEEN Ann County Md.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business AT HOME

MOTHER / FATHER
12. Name THOMAS DELAHAY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ARRIANNA PORTER
15. Birthplace MARYLAND

16 (a) Informant MRS. ARRIE A. GRIFFISS
(b) Address 516 CHARING CROSS ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 14-48 (month) (day) (year)
(c) Cemetery or crematory MEADOW RIDGE MEMORIAL
Location DORSEY, MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

SEP 14 1948 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH SEPTEMBER 12 19 48 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 19 46 to Sept 11 19 48 and that I last saw her alive on Sept 11 19 48

Immediate cause of death: Cerebral thrombosis — Duration 3 days

Due to Arterio sclerosis + diabetes mellitus. — Duration several yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Bowman Hood
Address 2200 CARRISON BLVD. Date signed 9/13/48 M. D.

Dr. Bowman Hood. X

66808 2603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 66808 Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? No — (Yes or No)
If yes, name country

3 (a) FULL NAME: FRANCIS NORMAN BALDWIN

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. 215-10-7058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Marie E.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) MAR-26-1894

8. AGE: Years	Months	Days	If less than one day
54	5	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business Globe Tavern

FATHER 12. Name Howard Baldwin
13. Birthplace Md

MOTHER 14. Maiden Name Catherine O'Donnell
15. Birthplace Md

16 (a) Informant Marie E. Baldwin wife
(b) Address 2709 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Hyker & Son
(b) Address 130 E. Eutaw Place

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948, at 11 29 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-9 1948 to 9-12 1948 and that I last saw h[illegible] alive on 9-12 1948

Immediate cause of death	Duration
Cardio resp failure	
Cerebral hemorrhage	
Due to Hypertension - Cir	
Due to Renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Kimble MD M. D.
Address St. Agnes Hospital Date signed 9-12

666809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 666809

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1044 Stockton St.

(c) Hospital or institution:

16 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1044 Stockton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Sydnor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Keziah Sydnor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12 1874

8. AGE: Years 73 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Spencer Sydnor

13. Birthplace Lancaster Co. Va.

MOTHER 14. Maiden Name Fannie

15 Birthplace Lancaster Co. Va.

16 (a) Informant Randolph Sydnor

(b) Address 312 N. Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948. (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie L. Williams

(b) Address 322 N. Schroeder St.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 10 1948

and that I last saw h[illegible] alive on Sept 10 1948

Immediate cause of death Pulmonary Embolism — Duration 1 day

Due to Fracture r. neck of femur — Duration 3 wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N+1

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 8-23-48 at ? M

(c) Where did injury occur? 1044 Stockton St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury Stumbled + fell + floor

23. Signature H. Garland Shirell M.D.

Address 102 W. Franklin Date signed 9-14-48

Howard J. Madden, M.D. ×

VS 150

666810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 471

666810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31 St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Philadelphia
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5445 Westminster Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WAVERLY ALEXANDER TAYLOR

3 (b) If veteran, name war: VA 2

3 (c) Social Security Account No. 217-18-0485

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Joy Taylor

6 (c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.) April 29, 1922

8. AGE: Years 26 | Months 4 | Days 25 | If less than one day: 4 hr. min.

9. Birthplace: Meredethville, Va. (Town, county, and state)

10. Usual Occupation: Student

11. Industry or business

FATHER
12. Name: Montford Taylor
13. Birthplace: Va.

MOTHER
14. Maiden Name: Harriet
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nat'l. Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. Geary St. Hyacinth
(b) Address: 1631 Druid Hill Ave.

19 (a) SEP 14 1948 (Date received by registrar) Tuntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Sept. 13 1948, and that I last saw him alive on Sept. 13 1948.

Immediate cause of death: Carcinoma of right lung with metastases — Duration: About 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in each place)
(e) Means of injury

23. Signature J. J. Van Acheren, Medical Director
Medical Officer in Charge
Address Date signed 9/13/48

VS 159

66811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 J

Registered No. 66811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos 24 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lombardee Beach (If outside city or town limits, write RURAL, and give town)
(d) Street No. Glen Burnie, P.O. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella L. Evans

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F.	W.	Widow

6 (b) Name of husband or wife Charles V. Evans
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 30-1885

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	10	13	14	

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Granville Myers
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Wine
15. Birthplace Pennsylvania

16 (a) Informant Ella Evans (deceased)
(b) Address Charles L. Daily - Glen Burnie, P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3601 Falls Road

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 19 . at 2.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1948 to Sept 13 1948 and that I last saw h[illegible] alive on 19

Duration

Immediate cause of death Respiratory Arrest

Due to Adenocarcinoma of rectum with metastasis to liver and epigastric nodes

Due to Benign essential hypertension

Other Conditions Poor appetite, nausea, [illegible]

(Include pregnancy within 3 months of death)

Date of operation 5/28/48

Major findings of operation: Adenocarcinoma of rectum with metastasis to liver and epigastric nodes

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify public place)
(e) Means of injury

23. Signature J. A. Kantner M. D.
Address 1 Armistead Gdns. Balto-11, Md.
Date signed 9/13/48

VS 150

66812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124C

66812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., ~~days~~) 3½
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Katherine A. Upton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John E.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-01

8. AGE: Years 47 | Months 4 | Days 15/14 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wm E. Marsh
13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna Latier
15 Birthplace Balto Md

16 (a) Informant Mrs Esther Fisher (sister)
(b) Address 2860 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month, day, year)
(c) Cemetery or crematory Balto Natl Cem
Location 5501 Frederick Ave

18 (a) Funeral director John J. Conway & Son
(b) Address 901-03 Hollins St.

19 SEP 14 1948 Huntington Williams, M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1948, at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1948 to 9-17 1948, and that I last saw her alive on 9-17 1948.

Immediate cause of death	Duration
Heart Failure acute	
Due to Pulmonary edema	1 hr
Due to Portal cirrhosis of liver	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-10

Major findings of operation: Portal cirrhosis, Ascites

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Harry V. Chase (or Judd M.D.)
Address Mercy Hospital Date signed 9-17

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

836

Registered No. 666813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Elm Ave.
(c) Hospital or institution:

13-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi C. Buffington.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married.

6 (b) Name of husband or wife Phoebe Buffington.
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	4	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Foreman, Retired.
11. Industry or business Textile Mills.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Phoebe Buffington.
(b) Address 3628 Elm Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept. 16/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 14 1948 Huntington Williamsport
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948. at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948. to Sept 13 1948.
and that I last saw h / m alive on Sept 13 1948.

Immediate cause of death: Cardio respiratory failure — Duration:
Due to Cerebral Hemorrhage
Due to Arteriosclerosis
Other Conditions Senility.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Grayson M. D.
Address 846 W 34th St Date signed Sept 14 48

666814

Registered No. 16

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Edmund SCUDDER

3 (b) If veteran, name war: WW II

3 (c) Social Security Account No. 215-24-5569

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1928

8. AGE: Years 20 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace Binghamton, N.Y. (Town, county, and state)

10. Usual Occupation Quilter.

11. Industry or business Int. Bedding Co.

FATHER
12. Name Charles Scudder
13. Birthplace Fla.

MOTHER
14. Maiden Name Mildred Ann Rackett
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept 15, 48 (month) (day) (year)
(c) Cemetery or crematory Lerraine Park.
Location

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12, 1948, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24, 1948, to Sep 12, 1948, and that I last saw him alive on Sep 12, 1948.

Immediate cause of death: Tuberculous meningitis — Duration: ?

Due to: Tuberculous spondylitis — Duration: 1 yr.

Due to:

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation Apr 20, 1948

Major findings of operation: as above

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. G. Morrow, M.D.
Address Marine Hospital Date signed 9/12/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AC-41-1948

BALTIMORE CITY HEALTH DEPARTMENT

666815

Registered No.

66815 BC-48-14208 A. 644 19

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

66815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rucker -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-8-48

8. AGE: Years 2 | Months | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Chas. Rucker
13. Birthplace Va. -

MOTHER 14. Maiden Name Dorothy Lawrence
15. Birthplace S. C. -

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore, Md

18 (a) Funeral director Elroy Fuller
(b) Address 1001 Bloomingdale Ave Baltimore, Md

19 SEP 14 1948 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Sept 11 1948 and that I last saw him alive on Sept 11 1948

Immediate cause of death Convulsions — Duration

Due to Cerebral anoxia secondary to

Due to Shock associated with acute Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cerebral Edema

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Mitchell Marchant M. D.
Address Johns Hopkins Date signed 9-13-48

VS 150

G66816 Dr. Merrill on Manslaughter ✓ G66816

Re in murder 9/24/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7420 Brightside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Enrico (Henry) Gabriele

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2728

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Elizabeth M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7 1895

8. AGE: Years 52 | Months 9 | Days 4 | If less than one day: hr. min

9. Birthplace: Teramo Italy
(Town, county, and state)

10. Usual Occupation: Forman

11. Industry or business

FATHER
12. Name: Beniamino Gabriele
13. Birthplace: Italy

MOTHER
14. Maiden Name: Virgilia Giacomelli
15. Birthplace: Italy

16 (a) Informant: Elizabeth M. Gabriele (Wife)
(b) Address: 7420 Brightside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15/48 (month)

(c) Cemetery or crematory: New Cathedral
Location: 4300 Old Frederick Rd.

18 (a) Funeral director: Frank Dell's Sons
(b) Address: 322 S. High St.

19 (a) SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive cardiac failure probably
Due to electric shock
Other Conditions Frac. left tibia & fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at 10:30 a. M.
(b) Where did injury occur? Windsor Lane, Catonsville
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Contact with live wire

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 9/11/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. 666817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1535 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: RAYMOND CHARLES WELLS

3 (b) If veteran, name war: Va 2

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Dec. 26, 1899

8. AGE: Years: 48 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Conductor

11. Industry or business:

FATHER
12. Name: John D. Wells
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Baum
15 Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk.
Location: 3801 Frederick Rd

18 (a) Funeral director: Harry H. Nitzke
(b) Address: 4/ Edmondson ave

19 (a) SEP 14 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12 1948, at 4:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1948, to Sept. 12 1948, and that I last saw h im alive on Sept. 12 1948.

Immediate cause of death: Hemorrhage from esophageal varices — Duration: 12 hrs.

Due to:

Due to:

Other Conditions: Laennec's cirrhosis — Unknown
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J.F. van Ackeren, Medical Director
Address: Medical Officer in Charge Date signed 9/13/48

VS 150

100a

BC-C95674 G66818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G66818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Patapsco Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sharron C. Sterry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/47

8. AGE: Years	Months	Days	If less than one day
	9	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Warren Sterry
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Crook
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Baltimore Highlands

18 (a) Funeral director Martin L. Gorman
(b) Address 1 [illegible] Ave

19 (a) SEP 14 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/48 19 , at 8:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/48 19 , to 9/13/48 19 . and that I last saw her alive on 9/13/48 19

Immediate cause of death	Duration
Meningitis and Bilateral Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: see above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hawn M. D.
Address 500 Bolton Hill Road Baltimore 30, Md. Date signed 9/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Coal Pier, 2200 S. Clinton St.
(c) Hospital or institution: (Found floating in harbor)

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown Baby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day hr. ? 5 min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 14 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1948, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, ~~undetermined~~ ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogl M.D.
Medical Examiner
Date signed 7/24/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

066820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

Registered No. 066820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Harve de Grace Rt. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel F Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1938

8. AGE: Years 10 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Severna, Md
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business at school

FATHER 12. Name Daniel F. Hill

13. Birthplace Va

MOTHER 14. Maiden Name Doris Medley

15. Birthplace Va

16 (a) Informant Daniel F Hill

(b) Address Rt. 2 Harve de Grace Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)

(c) Cemetery or crematory Angel Hill

Location Harve de Grace

18 (a) Funeral director Pennington & Son

(b) Address Harve de Grace Md

19 SEP 15 1948 (Date rec'd by registrar) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 12.05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intercranial Hemorrhage - Compound Fracture of the Skull

Due to Gun shot wound of the skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-11-48 at 1.30 P.M.

(b) Where did injury occur? Harve de Grace

(c) Did injury occur at home, on farm, industrial place, in public place? Home (yard) While at work? No

(d) Means of injury Hunting accident

23. Signature Robert B. Mcgeddon M.D.
Medical Examiner.

Date signed 9-12-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124A

Registered No. G66821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Don Jordan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Aug 11 1888
8. AGE: Years 60 | Months 1 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Don Jordan
13. Birthplace

MOTHER
14. Maiden Name Fronia Jacobs
15. Birthplace

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md
18 (a) Funeral director Tilman Cook Inc
(b) Address 1219 E Fort Ave Baltimore Md
19 SEP 15 1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-48 19 , at 1:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-48 19 , to 9-12-48 19 .
and that I last saw him alive on 9-12- 19 .

Duration
Immediate cause of death Resp failure
Due to: cirrhosis of liver
Due to: Dehydration Chronic alcoholism
Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. Hahn M. D.
Address University Hosp Date signed 9-13-48

VS 150

66822 66822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W Fayette St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Wilbur Talbott Sr

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1948, at 10:55 P M

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-12-1851

8. AGE: Years 96 | Months 9 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Hat Blocker

11. Industry or business New England Hat Co

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Frank Dyerbaugh
(b) Address 506 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral [redacted]
Location Baltimore - Md

18 (a) Funeral director William Cook Inc.
(b) Address 119 St Paul St

SEP 15 1948 (Date) received by Registrar Huntington Williams, M.D.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Colon
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature William S Talbott M.D. Medical Examiner.
Date signed Sept 14, 1948

VS 151

66823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. 668223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice J. Toney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband ~~or wife~~ Geo. W.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Aug 10. 69

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	1	3.		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. D. Smith
13. Birthplace Balto.

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mrs. "Elsie" Buckingham
(b) Address 529 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 48 (month) (day) (year)
(c) Cemetery or crematory Bulls Church
Location North Ave & Ivy

18 (a) Funeral director Agnes M. Ivy
(b) Address 1203 No. Broadway

SEP 15 1948 (Date rec'd by registrar) (b) Burlington 11 Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13. 1946 at 6:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/12/48 to 9/12/48
and that I last saw her alive on 9/12/48

Immediate cause of death Carcinoma of Liver

Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O Wesson MD M. D.
Address 1927 E North Ave Date signed 11-14-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 42

G66824 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Fremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alonzo Johnson

3 (b) If veteran, name war: War 1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Alonzo Johnson
13. Birthplace md

MOTHER
14. Maiden Name Elizabeth Douglas
15. Birthplace md

16 (a) Informant Beatrice Christy
(b) Address 601 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-48 (month) (day) (year)
(c) Cemetery or crematory Burr Hill Cem
Location Annapolis. md

18 (a) Funeral director Jamie A Hayes
(b) Address 142 West St

19 SEP 15 1948 (Date rec'd by registrar) (Signature of registrar)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1948 to Sept 13 1948. and that I last saw h[illegible] alive on Sept 13 1948

Immediate cause of death: Coronary Thrombosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4 Park Pl Date signed 9-15-48
Charles F. Woodland

Medical & Chemical Case

Released by medical examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186A

Registered No. 666825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland St. and Ferguson Ave.
(c) Hospital or institution:
West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph S. Ferguson FERGUSON.

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Edna K. Ferguson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1888

8. AGE: Years 59 | Months 10 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Wm. M. Patterson Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. E. Marjorie Towson
(b) Address 2903 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 19 48, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 19 48, to Sept 14 19 48, and that I last saw him alive on Sept. 14 19 48.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Fr Intracranial hemorrhage	
Due to Fractured skull	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 11 '48

Major findings of operation: Fractured skull & intra-cranial hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 10th at ? M
(c) Where did injury occur? Balto (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps (inside)

23. Signature Katharine F. Kemp M. D.

Address West Balto. Gen. Hosp. Date signed Sept. 14, 1948

William H. Kammer, Jr., M.D. per: Kat Kemp

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G66826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 No Smallwood St
(c) Hospital or institution: 15-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No 1804 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Shapiro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Myer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Goldie
15. Birthplace Russia

16 (a) Informant Myer Shapiro
(b) Address 1804 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14- 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to 19 , and that I last saw h alive on Apr. 14 1948.

Immediate cause of death: Pulmonary edema
Cardiac failure
Duration:

Due to Arteriosclerotic Cardiosclerosis

Due to Parkinsonism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. G. Kessler

Address 814 W. North Ave Date signed 9/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66827

BALTIMORE CITY HEALTH DEPARTMENT 94A Registered No. 66827

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or Institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ...
(c) City or town Rural - Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Creek Drive, Rockhill Beach (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ...

3 (a) FULL NAME Elzey L. Sank

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret M.
6 (c) If [illegible], give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1881

8. AGE: Years 66 | Months 11 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Son Mr. Sank
(b) Address 2 Clearwater Beach Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Harry A. Smith
(b) Address 4101 Edmondson Ave

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1948, at 2 30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-11 1948 to 9-12 1948, and that I last saw h[illegible] alive on 9-12 1948

Immediate cause of death	Duration
Acute Pulmonary Edema	5 hr.
Due to Anterior Myocardial Infarct.	3 days
Due to Coronary Thrombosis	3 days

Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: Anterior Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Powell M. D.
Address 1213 Light St. Date signed 9-12-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

066828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(1931)

066828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place 28
(c) Hospital or institution: Balto. Eye Ear & Throat Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street address Hebrew German Aged People's Home 225 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3. (a) FULL NAME Henry Conrad Fredrick Bergen.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married.
6 (b) Name of husband or wife [redacted]
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) 1-3-70.
8. AGE: Years 78 | Months 11 | Days 8 | If less than one day hr. min.
9. Birthplace Baltimore City. (Town, county, and state)
10. Usual Occupation Retired Tailor.
11. Industry or business Tailor.

FATHER
12. Name Eberhard Bergen
13. Birthplace Germany.

MOTHER
14. Maiden Name Amalie Fuchs
15. Birthplace Germany.

16 (a) Informant Wife.
(b) Hebrew German Aged People's Home of Balto.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17-48 (month) (year)
(c) Cemetery or crematory Lorraine [illegible]
Location Woodlawn
18 (a) Funeral director Harry H. Wilkes
(b) Address 1701 Eutaw Pl.
19 (a) SEP 15 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948. at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948. to Sept 14 1948 and that I last saw him alive on Sept 14 1948.

Immediate cause of death: Cardiac decompensation

Due to: Chronic hypertension 3

Due to:

Other Conditions: Pt. Not operated for following Cystoscopic Examination Sept 9 1948

(Include pregnancy within 3 months of death)

Date of operation Sept 9. 1948

Major findings of operation: Mature Cataract - Left Eye.

of autopsy:

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at. M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Hayes Lathrop M.D.
Balto. Eye Ear Throat Hosp.
1214 Eutaw Place Date signed Sept 14-48

VS 8

666829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

666829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. MONROE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARLAND H. MARTIN SR

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-8849

MEDICAL CERTIFICATION 1-E

20. DATE OF DEATH September 14 1948 at 4 A M

4. Sex MALE | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** MARRIED

6 (b) Name of husband or wife MARIE V. MARTIN

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 16-1889

8. AGE: Years 58 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace CHARLES TOWN W. VA
(Town, county, and state)

10. Usual Occupation MEAT CUTTER

11. Industry or business

FATHER
12. Name Richard N. MARTIN
13. Birthplace Virginia

MOTHER
14. Maiden Name ANNIE R. WILLIAMS
15. Birthplace Maryland

16 (a) Informant MARIE V. MARTIN
(b) Address 410 S. MONROE ST

17 (a) BURIAL (b) Date thereof Sept 17 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Edge Hill Cem.
Location Charles Town W Va

18 (a) Funeral director Pat C. B. M. Walters
(b) Address Front & Stricker Sts

19 SEP 15 1948 (b) Huntington Williamson, W Va
(Date rec'd by registrar) Registrar

Immediate cause of death Carcinoma of colon — Duration 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation May 11 1948

Major findings of operation: Carcinoma of colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify which place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address US 30 Wilkes Date signed 9/14/48

and X

VS 150

66830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 66830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. GILMOR ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA MAUDE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1906

8. AGE: Years 42 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Essex County, Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Buckley, Noel
13. Birthplace Virginia

MOTHER
14. Maiden Name Hattie Carter
15. Birthplace Va.

16 (a) Informant Maggie Waller
(b) Address 406 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 SEP 15 1948 (Date rec'd by registrar) (b) Interior Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1948, at 8:17 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1948, to 9-13 1948, and that I last saw h[illegible] alive on 9-11 1948.

Immediate cause of death: RUPTURED ABDOMINAL AORTIC ANEURYSM — Duration:

Due to: ABDOMINAL AORTIC ANEURYSM — 1 yr?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 N. Franklin St Date signed 9-13-48

VS 150

66831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. 66831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JESSIE JONES

3 (b) If veteran of the war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Ruth Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1918

8. AGE: Years	Months	Days	If less than one day
30	3	3	hr. min.

9. Birthplace Raleigh, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Water Department

FATHER
12. Name Samuel Jones
13. Birthplace Franklin Co. Va.

MOTHER
14. Maiden Name Lucille Yarbrough
15. Birthplace Waite County, Va

16 (a) Informant Lelia Anderson
(b) Address 1305 Myrtle Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Raleigh N.C. ~~Richmond~~, Va
Location

18 (a) Funeral director Mr Katie R Williams
(b) Address 322 E. Lehmden St.

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948, at 3 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of left femoral artery.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at A. M.
(b) Where did injury occur? 749 Wilmer Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Sharp Instrument

23. Signature George A. Merrill M.D. (Medical Examiner)
Date signed 9-11-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

✓ 666832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Hilton St.,
(c) Hospital or institution: 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 91-3-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 N. Hilton St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Martina Lewis

3 (b) If veteran, name war ---
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1857

8. AGE: Years	Months	Days	If less than one day
91	3	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business Balto. City

FATHER
12. Name Thomas Lewis
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary M. Veara
15. Birthplace Madeira

16 (a) Informant Miss Jennie M. Lewis
(b) Address 1711 N. Hilton St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-1948 (month) (day) (year)
(c) Cemetery or crematory xx Greenmount
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 1948 (b) Rec'd by registrar Washington Williams, Registrar

MEDICAL CERTIFICATION 9.15

20. DATE OF DEATH Sept. 13, 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1948 to Sept 13 1948, and that I last saw her alive on Sept 13 1948.

Immediate cause of death arteriosclerotic Hypertensive Cardio Vascular disease — Duration years?
Due to
Due to
Other Conditions Carcinoma of right breast — 6 months
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Sullivan M. D.
Address 291 Barrison Blvd Date signed 9-15-48

V-3 150

93 D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Fusting 666833 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666833
11 E Chase CERTIFICATE OF DEATH 93D Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (949 Montpelier St.
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 949 Montpelier Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick P. Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Catherine A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 6, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retried
11. Industry or business

FATHER
12. Name Frederick Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15 Birthplace Germany

16 (a) Informant Mrs. Jennie Herrmann
(b) Address 949 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305, Harford Road #14

19 (a) Date received by registrar SEP 15 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 6.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947, to 9-13 1948.
and that I last saw him alive on 9-13 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertensive - Arteriosclerotic	?
Due to C-V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William H. Fusting M.D.
Address 11 E. Chase St. Date signed 9-14-48

X

Dr. Lilienfeld 714 E. Preston

G66834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G66834 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1705 Holbrook Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1705 Holbrook Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Ann Fishpaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	8	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name John Frank

13. Birthplace Md.

MOTHER 14. Maiden Name Anna ?

15. Birthplace Md.

16 (a) Informant Mr. John W. Fishpaugh

(b) Address 1705 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road #14

19 (a) Date received SEP 15 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1948 to Sept 14 1948, and that I last saw her alive on Sept 13 1948.

Immediate cause of death: Uremia — Duration: 5 days

Due to: Cardio-Vascular renal disease

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Samuel Lilienfeld M. D.

Address 714 E. Preston Date signed Sept 15 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

G66835
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Rose Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND CROSS, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1948

8. AGE: Years — | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roland Cross, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rita Kuzma
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Holy Redeemer
Location 4430 Belair Rd., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

SEP 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

DEAD MEDICAL CERTIFICATION ON ARRIVAL

20. DATE OF DEATH Sept. 14 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948, to Sept 14 1948, and that I last saw him alive on Sept 14 1948.

Immediate cause of death asphixiation of food — Duration Life

Due to weakness & swallowing musculature MUSCULATURA

Due to Angiotonia Congenita AMYATONIA CONGENITA

Other Conditions Pectus Excavatus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature O'Neill Lysaught, M.D.
Address Johns Hopkins Hosp. Date signed 9-15-48

Released to HOSPITAL To Be Approved By Medical Examiner

VS 150

MEDICAL EXAMINER'S CASE

666836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 F

Registered No. 666836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 S. Fremont Ave
(c) Hospital or institution: D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Nolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1917.

8. AGE: Years	Months	Days	If less than one day: hr.	min
31	10	5		

9. Birthplace A. A. County, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Scott Nolan
13. Birthplace Northumberland Co., Va.

MOTHER
14. Maiden Name Agnes Allen
15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Bertha Stewart
(b) Address 614 S. Fremont Ave.

17 (a) Burial (b) Date thereof 9-15-1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Jones Md.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Richmond St. Huntingtown Calvert Co. Md.

19 (a) 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Pulmonary T.B.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schmidt M.D.
Medical Examiner.
Date signed 9/12/48

VS 151

666837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

666837 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 Fordleigh Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Fordleigh Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ANNA M. DEAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Max Dean.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1874.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	10	29		

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Meyers,
13. Birthplace Germany.

MOTHER
14. Maiden Name Augusta Prinz,
15. Birthplace Germany.

16 (a) Informant Mrs. Louise Loewenson,
(b) Address 3802 Fordleigh Road.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/16/48. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director David Armstrong & Son
(b) Address 1902 Eutaw Place.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 13th. 1948 at 11.45 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1942 to Sept 14 1948 and that I last saw her alive on Sept 13 1948.

Immediate cause of death	Duration
Acute pulmonary edema	2 hours
Due to Coronary thrombosis	6 hours
Due to	
Other Conditions Hypertension	6 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St. Date signed

VS 150

666838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94-A

666838 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT ARNOLD JONES) Robert Jones

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-01-5236

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose B. (Donohue) Jones

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1894

8. AGE: Years: 54 | Months: 8 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Estimator

11. Industry or business: Monitor Controller Co.

FATHER
12. Name: Robert D. Jones
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Belle Horney
15. Birthplace: Maryland

16 (a) Informant: Mrs. Rose B. Jones
(b) Address: 1704 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/15/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) 9-15 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-14 1948, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. P. Schmidt Medical Examiner. M.D.
Date signed: 9-15-48

Please type or print plainly. Physicians: please write the cause of death clearly and legibly.

66839 BALTIMORE CITY HEALTH DEPARTMENT ✓ 66839
CERTIFICATE OF DEATH 461 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Kenyon ave.
(c) Hospital or institution: 213
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Kenyon ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL JAMES MOLONEY

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary H. Moloney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 21, 1893

8. AGE: Years 54 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Policeman (Retired)

11. Industry or business Baltimore City

FATHER 12. Name Michael Moloney
13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Carberry
15. Birthplace Ireland

16 (a) Informant Mrs. Mary H. Moloney
(b) Address 3211 Kenyon ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) (Date received by registrar) (b) Registrar

SEP 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 14 1948, and that I last saw him alive on Sept 13 1948.

Immediate cause of death: Carcinoma of Rectum — Duration

Due to

Due to

Other Conditions: Cirrhosis of Liver Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: April 1948 Carcinoma

Major findings of operation: Carcinoma of Liver

of autopsy: METASTASIS

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M.D.
Address 3001 Shannon Drive Date signed 9/14/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666840 Room 666840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131-

Registered No. 666840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 33 | Months | Days | If less than one day: hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ben Harvey
13. Birthplace ?

MOTHER
14. Maiden Name Mary Lee Williams
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 16 48 (Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. Co.

18 (a) Funeral director Elliott Brangton
(b) Address 1116 N. Caroline St.

19 (a) SEP 15 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 12 1948 to 9 12 1948 and that I last saw her alive on 9-12-1948.

Immediate cause of death: Respiratory Collapse. — Duration: minutes

Due to: Fibro-caseous pulmonary Tuberculosis with Cavitation — Duration: months.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Tbc. & Cavitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Courtney J. Iggo. M. D.
Address 1st Hill Hospital Date signed 9-13-48

To be Approved by Medical Examiner

VS 199

666841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDWARD WHITE

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M
5. Color or race col
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Florence White
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr) Jan. 13 ?
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace Oriole, Md. (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Mat White
13. Birthplace Oriole, Md.

MOTHER
14. Maiden Name Adelaide Holland
15 Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19. 1948 (month) (day) (year)
(c) Cemetery or crematory St. James. Cem.
Location Oriole. Md.

18 (a) Funeral director Elroy. C. Wilson
(b) Address 1030 Brantly Ave.

19 (a) SEP 15 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 7:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 8 1948 to Sept. 14 1948 and that I last saw him alive on Sept. 14 1948

Immediate cause of death Adeno Carcinoma of right lung with metastases to lymph nodes, thyroid, kidneys, adrenalin, liver and
Due to right humerus with pathologic
Due to fracture

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration
Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature J. F. van Ackeren, Medical Director
Address Medical Officer in Charge Signed 9/14/48

VS 159

G66842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

G66842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Fleet St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anthony August Gruebl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Katherine Cecilia Gruebl 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-20-02

8. AGE: Years	Months	Days	If less than one day
45	10	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business Cooper's Co.

FATHER 12. Name George Gruebl
13. Birthplace Germany

MOTHER 14. Maiden Name Theresa Klopp
15 Birthplace Germany

16 (a) Informant Diseased
(b) Address 1939 Fleet St., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Tully & Zeller
(b) Address 463 Huntington Ave., Baltimore, Md.

SEP 15 1948
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 7:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 14 1948. and that I last saw h[illegible] alive on Sept 14 1948.

Immediate cause of death	Duration
Overwhelming Infection.	
Due to Agranulocytosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of autopsy: Lymphosarcoma of retroperitoneal lymph nodes and spleen & liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature John M. Rebleza M. D.
Address St. Joseph Hospital Date signed 9-14-48

76a

VS 150

48-13313
G66843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G66843 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Lyons A Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1948

8. AGE: Years 2 (22 M) | Months | Days 21 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roberts Harris
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lee Estes
15. Birthplace Virginia

16 (a) Informant: Robert Harris
(b) Address 1848 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto County, Md.

18 (a) Funeral director Charles H Gorter & Sons
(b) Address 2112 Connecticut Ave

19 (a) Date rec'd by registrar SEP 15 1948 Registrar Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1948 at 10:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions 2nd & 3rd degree Burns surface & extremities
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 Sept 48 at 1 A. M.
(b) Where did injury occur? 928 N. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fire at Home - Thrown from window

23. Signature Earl L Royster M.D.
Medical Examiner

Date signed 12 Sept 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666844 (GRV 666844) (GC-C 78153) 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16-H
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1946

8. AGE: Years	Months	Days	If less than one day
2	4	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	Alvin Harris
	13. Birthplace	Balto., Md
MOTHER	14. Maiden Name	Annie Enght
	15. Birthplace	North Carolina

16 (a) Informant Robert Harris
(b) Address 1841 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County Md.

18 (a) Funeral director Chas H Corbin
(b) Address 512 Carrollton Ave.

19 (a) (Huntington Williams, M.D.)
(Date received by registrar) SEP 15 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 3:30 AM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd° and 3rd° Burns Entire Body Surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A.M.
(b) Where did injury occur? 928 N Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McFadden M.D. Medical Examiner.
Date signed 9-12-48

Correct ages if especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66845

66845 BC-8-85422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Harris Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-44

8. AGE: Years 4 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alvin Harris
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Knight
15. Birthplace North Carolina

16 (a) Informant Robert F. Harris
(b) Address 1848 Pennsylvania Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County, Md

18 (a) Funeral director Chas. H. Garten
(b) Address 612 Carrollton Ave.

19 (a) SEP 15 1948 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2° and 3° Burns of the entire body surface.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A.M.
(b) Where did injury occur? 928 Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McAdden M.D. (Medical Examiner.)

Date signed 9-12-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G666846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G666846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ELSIE HARRIS

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert F. Harris

6 (c) If alive, give age: 3 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1910

8. AGE: Years: 38 (D) M | Months: 8 | Days: 12 | If less than one day: ..... hr. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business .....

MOTHER | FATHER

12. Name: Samuel Bell

13. Birthplace: Virginia

14. Maiden Name: Rose Brandon

15. Birthplace: Virginia

16 (a) Informant: Robert Harris

(b) Address: 1848 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem'l. Pk.
Location: Balto County. Md

18 (a) Funeral director: Charles E. Cooper

(b) Address: 512 N. Carrollton Ave

SEP 15 1948 (Date rec'd by registrar) Washington Hollow Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1948 at 10:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Extensive burns

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-12-48 at ~~1 o'clock~~ Approx. A. M.

(b) Where did injury occur? 928 N Fulton Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) No

(d) Means of injury Conflagration

23. Signature George E. Merrell M.D.
Examiner.

Date signed 9-13-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G666847 / 016 ✓ G666847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Harris Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1926

8. AGE: Years	Months	Days	If less than one day
22	6	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Self

FATHER
12. Name Robert Harris
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Edie Tribbs
15. Birthplace Virginia

16 (a) Informant Robert Harris
(b) Address 1849 Pennsylvania Ave.

17 (a) Burial (b) Date thereof 9/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore County Md

18 (a) Funeral director Chas. H. Sturdivant
(b) Address 512 Carrollton Ave

19 (a) [illegible] (b) [illegible] Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 2:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2° and 3° Burns of the entire body surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A M.
(b) Where did injury occur? 928 N. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McAdden M.D.
Medical Examiner.
Date signed 9-12-48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harbold G66848

4706 Harford

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6113 Sefton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6113 Sefton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Elizabeth Shipman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife William M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 26, 1904

8. AGE: Years	Months	Days	If less than one day
43	8	18	hr. min.

9. Birthplace Phillipsburg, N.J. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Frederick Mamber

13. Birthplace Germany

MOTHER 14. Maiden Name Fredericka Rau

15. Birthplace Germany

16 (a) Informant Mr. William M. Shipman

(b) Address 6113 Sefton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)

(c) Cemetery or crematory St. James Luth Cem.

Location Phillipsburg, New Jersey

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1948 to Sept 13 1948. and that I last saw her alive on Sept 13 1948.

Immediate cause of death Hodgkins Disease — Duration 4 years

Due to

Due to

Other Conditions Pulmonary edema Abdominal lymphadenopathy (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.

Address 4706 Harford Road Date signed 9/15/48

SEP 15 1948

VS 150

Physicians: please write the causes of death clearly and legibly. Exact age is especially important. The space provided for the medical certification must be completely filled in. Use supplement if necessary.

Dr. Harbold 666849 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666849 Registered No.

CERTIFICATE OF DEATH 46 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Reuckert Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Reuckert Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Poehlman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 9, 1882

8. AGE: Years	Months	Days	If less than one day
66	2	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name William Mayers
13. Birthplace Md.

MOTHER 14. Maiden Name Minnie Schmidt
15. Birthplace Md.

16 (a) Informant Mr. Edmund Poehlman
(b) Address 2816 Reuckert Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 23 1945 to Sept 14 1948 and that I last saw her alive on Sept 11 1948

Immediate cause of death Carcinoma of Caecum c metastasis — Duration 1 1/2 years

Due to

Due to

Other Conditions Pulmonary tuberculosis 20 yrs. Chronic myocarditis Chronic interstitial nephritis

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.
Address 4706 Harford Road Signed 9/15/48

Please print age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 66850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Fremont Ave
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joseph G. Roberts (Rutasheosky)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name Joseph Roberts
13. Birthplace Lith.

MOTHER
14. Maiden Name Lithe Zubkauskas
15. Birthplace Lith

16 (a) Informant Joseph Bagtill
(b) Address 226 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore Md

18 (a) Funeral director Joseph Kasmauskas
(b) Address 602 Washington Blvd Balto

19 SEP 16 1948 (b) Baltimore Md (Registrar)
(Filled in by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1948 to 9-13 1948 and that I last saw h[illegible] alive on 9-13 1948

Immediate cause of death: Myocardial degeneration — Duration 1 mo
Due to: Chronic myocarditis
Due to: Coronary Artery Disease — 2 mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Unlock Jr M. D.
Address 1227 Keyser Bldg Date signed 9-14-48

VS 150

66851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66851 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Park Heights Ave
(c) Hospital or institution:
15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE RUDMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER 12. Name Benjamin Segelman

13. Birthplace Russia

MOTHER 14. Maiden Name Rachael

15. Birthplace Russia.

16 (a) Informant Minnie Gordon

(b) Address 4230 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month)

(c) Cemetery or crematory Bnai Israel

Location Southern Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 2108 Eastern Ave

19 (a) SEP 16 1948 (b) Huntington Hollow, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/48 19 . at 10:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death).

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, in industrial place, in public place? While (state)

(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.

Date signed 9/15/48

VS 151

666852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Park Heights Ave
(c) Hospital or institution:
Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-3

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Pittsburgh Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Poland

MOTHER
14. Maiden Name Betty
15. Birthplace Poland

16 (a) Informant Mrs H F Wolfram
(b) Address 4502 Monument Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)

(c) Cemetery or crematory
Location Norfolk, Va

18 (a) Funeral director Mt Lewis Inc
(b) Address 2100 Eustan Place

19 (a) SEP 16 (Date rec'd by Local Reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-48 at 2.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 20. 48 to Sep 15 48 and that I last saw h[illegible] alive on Sep 15 48

Immediate cause of death	Duration
Due to Bronchial asthma Chron. Myocarditis	2yrs
Due to Edema Lung	2 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Saylor M.D.
Address 2140 Eustan Date signed 9/16/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127A

66853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 YORK RD.
(c) Hospital or institution:

27-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 YR.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 YORK RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR JERMIMAH SLADE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife JOHN E. SLADE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 20, 1858

8. AGE: Years	Months	Days	If less than one day
90	5	23	hr. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name ASBURY R. REILEY
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden Name JULIAN LOWE
15. Birthplace PENNSYLVANIA

16 (a) Informant A. R. SLADE
(b) Address 4907 YORK RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 16 48 (month) (day) (year)
(c) Cemetery ~~crematory~~ MORELAND MEMORIAL
Location BALTIMORE

18 (a) Funeral director HENRY W. JENKINS & SONS
(b) Address YORK RD. & ROSSITER AVE.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 10:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1948 to Sept. 13 1948 and that I last saw h e alive on Sept. 13 1948

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Cholecystatis	3 days
Due to	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl H. Benjamin M.D.
Address 5111 York Rd Date signed 9/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6668:54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. 6668:54

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 N. Market St.
(c) Hospital or institution: H. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 N. Market St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Olivia Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1913

8. AGE: Years 35 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laundry worker

11. Industry or business

FATHER 12. Name Albert Madden

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Myrtle Loveday

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bessie Harris

(b) Address 2004 Kelly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 SEP 16 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 7a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1948 to Sept 14 1948. and that I last saw her alive on Sept 14 1948.

Immediate cause of death: Hemiplegia — Duration: 2 months

Due to: Hypertension — Duration: 1 year

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Walsh M. D.

Address 1525 Linden Ave. Date signed 9-16-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6668:55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

6668:55 Registered No.

45-5-772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-E
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Jack Henry Hobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Mabel Hobbs
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 12-24-18

8. AGE: Years	Months	Days	If less than one day
29	8	18	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hobbs
13. Birthplace N. C.

MOTHER
14. Maiden Name Martha Brantley
15 Birthplace N. C.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Wm. D. Jackson
(b) Address 1918 Penna Ave

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1948 to 9-12- 1948 and that I last saw him alive on 9-12- 1948.

Immediate cause of death	Duration
Tuberculous meningitis	
Due to	
Due to	
Other Conditions (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Winternitz
Address Johns Hopkins Hospital Signed 9-15-48 M D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66856 JL - 122690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66856

1-9

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.

(e) Length of stay in Baltimore (yrs., mos., or days) ½ hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Bal. Co.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 124 Avon Beach Rd. -22
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Robinson-"A" - Pearl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1948

8. AGE: Years | Months | Days | If less than one day hr. 30 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Robinson

13. Birthplace ?

MOTHER

14. Maiden Name Pearl ?

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof Sept 9-9-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) SEP 16 1948 (b) Huntington Nolle Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Sept. 3 1948, and that I last saw her alive on Sept. 3 1948

Immediate cause of death Prematurity — Duration 2 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William A. Kean M. D.

Address Baltimore City Hosp. Date signed 9-9-48

VS 150

666857

JL - 122691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Avon Beach Rd. -22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Robinson "B" - Pearl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 3, 1948

8. AGE: Years	Months	Days	If less than one day
			hr. 55 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Robinson
13. Birthplace ?

MOTHER
14. Maiden Name Pearl ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9 am 9-9-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Address Baltimore City Hospitals Date signed 9-9-48

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 19 48 at 10.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept. 3 1948. and that I last saw her alive on Sept. 3 1948.

Immediate cause of death

Duration 55 min.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hospital Diagnosis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666858

A65366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Jeffrey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Charlillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	32 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Anthony Charlillo
13. Birthplace Ohio

MOTHER 14. Maiden Name Annicchiarico Da Marco
15 Birthplace N.Y.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 11 - 1948 at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1948 to 9-11- 1948 and that I last saw her alive on 9-11- 1948.

Immediate cause of death atelectasis and CNS damage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 9-11-48 at 12 15 A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Ryan M. D.
Address Johns Hopkins Hosp Date signed 9-11-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G668:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186 A

Registered No. G668:59

G668:59

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene

(c) Hospital or institution: University Hospital J-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3618 Edmor Rd. (18) (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Albert E. Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife LENA C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12th 1870

8. AGE: Years 78 Months 2 Days 2 If less than one day hr. min.

9. Birthplace missouri (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name albert smith

13. Birthplace California

MOTHER 14. Maiden Name Liza Butler

15. Birthplace missouri

16 (a) Informant pt himself.

(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9/17/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location " md.

18 (a) Funeral director William Cook Inc

(b) Address 217 St. Paul St

19 (Date rec'd by Registrar) SEP 16 1948 (Signature of Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 9/14 1948.

and that I last saw him alive on 9/14 1948.

Immediate cause of death	Duration
Resp. Cased.	
Due to Hypostatic pneumonia	1 day.
Due to Fracture, femoral neck, rt 4 days fracture, 9th rib, rt.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide J-3

(b) Date of occurrence 9/10/48 at M

(c) Where did injury occur? Balto (City or town) Balto (County) md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Bathroom of home (Specify type of place) While at work? no

(e) Means of injury fall- slipped fell to floor

23. Signature J R Davidson M. D.

Address Univ Hosp Balto, md. Date signed 9/14/48

Certified by J. Maloney M.D.

VS 180

Physicians: please write the causes of death clearly and legibly! It is especially important that correct age is given.

666860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 C

Registered No. 666860

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-R
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Cathedral St., Milner Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT (TOSIER) TOZER

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1873

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant BEATRICE MONDORFF
(b) Address 1604 PARK AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 16 1948 (b) Registered by Washington National Ins. Co.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1948, at 5 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-43 at P M?
(b) Where did injury occur? Milner Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? hotel While at work? no
(d) Means of injury Firearms

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 9/10/48

VS 151

666861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137A

666861 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Severna Pk (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife Minta
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) 11-20-76

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	9	25		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Marion Benjamin Watts
13. Birthplace Md

MOTHER
14. Maiden Name Letitia Marion Coleman
15 Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Jones Station
Location Jones Md.

18 (a) Funeral director J. O. Johnson
(b) Address 206 E. Annapolis, Md

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1948 to 9/15 1948, and that I last saw h[illegible] alive on 9/15 1948.

Immediate cause of death	Duration
Cardiac failure + pulm. edema	6 wks.
Due to Arteriosclerotic cardiovascular disease	10 yrs.
Due to	
Other Conditions Benign prostatic hypertrophy + recto urethral fistula	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation 8-24
Major findings of operation: Benign prost. hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify (a), (b), or (c) place)
(e) Means of injury
23. Signature W R Boothin M.D.
Address The Johns Hopkins Hospital Date signed 15 Sept '48

VS 130

93D

66862 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 66862

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Druid St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days) 66 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1419 Druid St (Rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME David Bowles

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 15 1948

18 (a) Funeral director Bureau of Health

(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/ 19 48 at 11 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 19 48 to 8/27 19 48; and that I last saw h alive on 8/27 19 48

Immediate cause of death (Duration)

Uremia

Due to Hypertension 15 yrs

Due to Cancer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Extensive Ca Uterus

of autopsy: Uremia, edema & Cyst

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M D

Address Provident Hospital Date signed 8/27/48

VS 150

Myers

666863 BALTIMORE CITY HEALTH DEPARTMENT 666863

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 York Rd. Towson
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie Mary Myers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife William Henry Myers Sr.
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Dec 15, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	29	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name George Stock
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Parks
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Bethmos
(b) Address 527 York Rd, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1948 (Month) (day) (Year)
(c) Cemetery or crematory Mays Chapel Cem.
Location Timonium, Balto. Co., Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 (a) SEP 16 1948 (Date received by Registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1948 at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948 to 9-14 1948. and that I last saw her alive on 9-7 1948

Immediate cause of death	Duration
Pulmonary Edema	2 hr
Due to Heart Failure	2 days
Due to Coronary occlusion	5 yrs
Due to A.S.C.V.D.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Smith, M. D.
Address Union Mem. Hosp Date signed 9/14/48

VS 150

G66864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Booth

3 (b) If veteran, name war: W.W.I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1895

8. AGE: Years 53 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant: Mary Booth
(b) Address 830 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 130 [illegible]

SEP 16 1948 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948, at 4 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypostatic pneumonia of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Emil L. Rogers M.D. (Medical Examiner)

Date signed 9-15-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

666865 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 W North Ave.
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W North ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Hyland Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1882

8. AGE: Years 66 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Moses Hackins
13. Birthplace Virginia

MOTHER
14. Maiden Name Nettie (unknown)
15. Birthplace Virginia

16 (a) Informant Rev. B. F. Jackson
(b) Address 1620 W North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Phila
Location Phila Pa

18 (a) Funeral director Lee-Ki-Kelson
(b) Address 1303 Pennsylvania Ave Huntington W. Va.

19 (a) (Date received by Registrar) Registrar

SEP 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948, to Sept 17 1948, and that I last saw h[illegible] alive on Sept 16 1948.

Immediate cause of death Bronchopneumonia — Duration 8 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 511 N. Schroeder St Date signed 9/16/48.

666866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666866

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Eagleside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellingham T. Walgrove

3 (b) If veteran, name war No

3 (c) Social Security Account No. -

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 23, 1886

8. AGE: Years 62 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace New York, City
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER 12. Name George Walgrove
13. Birthplace New York City

MOTHER 14. Maiden Name Catherine Douglas
15. Birthplace New York City

16 (a) Informant Hospital Record
(b) Address above.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 16, '48 (month, day, year)
(c) Cemetery or ~~crematory~~ Greenwood
Location Brooklyn, New York

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md. Huntington Williamsport, Md.

19 (a) SEP 16 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/1948, at 12:39 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/10/48

VS 151

666867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

666867

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: Hillcrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH E. BILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 18, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Bill
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth D'Alloe
15. Birthplace England

16 (a) Informant Dr. Edith E. Bill, niece
(b) Address 3301 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1948 at 11.00 P M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1947 to Sept 14 1948.
and that I last saw h PR alive on Sept 14 1948

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to acute Coronary occlusion	
Due to arteriosclerotic heart disease, chronic myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wentland Edmund Day M. D.
Address 4 E. 33rd St - 18 Date signed 9/14/48

VS 150

Please write plainly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Information should be carefully supplied.

666868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666868 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR W. COOK

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Judith D. Cook

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1886

8. AGE: Years: 62 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Atlanta, Ga. (Town, county, and state)

10. Usual Occupation: Field Engineer

11. Industry or business: Fire Insurance

FATHER
12. Name: Lewis Cook
13. Birthplace: Milledgeville, Ga.

MOTHER
14. Maiden Name: Sarah Caroline Caldwell
15. Birthplace: Lafayette, Ga.

16 (a) Informant: Mrs. Judith D. Cook
(b) Address: 3701 Clifton Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory
Location: Rutherford, N. J.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 16 1948 (Date rec'd by registrar) Thurlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26/ 1948 to 9/14/ 1948, and that I last saw him alive on Sept. 13 1948.

Immediate cause of death: cardiac failure — Duration: 2 mo.

Due to: carcinoma of prostrate gland — 2 yrs.

Due to:

Other Conditions: cerebrial arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar W. Kinyon M. D.
Address 3030 Edmondson Avenue Date signed 9/15/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

666869 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Okenshaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Louis Schreitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Helen A. Schreitz
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) June 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Broker
11. Industry or business

FATHER
12. Name John A. Schreitz
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine A. Shannon
15. Birthplace Maryland

16 (a) Informant Patient Wm. Louis Schreitz
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1948 (Date received by registrar) Fenton F. Gillespie M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1948, at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-14 1948, and that I last saw h, M alive on 9-14 1948.

Immediate cause of death	Duration
Acute Coronary occlusion	24 hrs.
Due to Coronary Artery Disease	2 yrs.
Due to	
Other Conditions Prostatic hypertrophy, Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John R. Smith, M.D.
Address Union Mem. Hosp. Date signed 9/14/48

9+2

666870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 666870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Welcome alley
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Welcome al
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Rawlings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12-11-1896

8. AGE: Years: 53 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Oxford Delaware
(Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business

FATHER — 12. Name: William Thompson
13. Birthplace: Oxford Delaware

MOTHER — 14. Maiden Name: Celeste
15. Birthplace: Oxford Del-

16 (a) Informant: Hattie Johnson
(b) Address: 5-8 E Oxford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St Huntington Williams, Reg.

19 (a) SEP 16 1948 (Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1948 at 5a M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/23 1948 to 9/13 1948, and that I last saw h[illegible] alive on 9/1 1948.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to: Hypertension	
Due to: Chronic Nephritis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Dr Trawick M.D.
Address 112 Welcome Date signed 9/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6687 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G66871
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied/ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Bruce Street
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Bruce ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Florence Peck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 22, 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	9	22		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Household
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Brown
15. Birthplace ?

16 (a) Informant Phyllis Everett
(b) Address 22 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1948, at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11, 1948, to Sept. 14, 1948, and that I last saw her alive on Sept. 13, 1948.

Immediate cause of death	Duration
CARDIAC Failure	Day
Due to Acute Pulmonary Congestion	2 Days
Due to Lobar Pneumonia	2 Days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 9-15-48

VS 150

666872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666872

666872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Overview Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Simon Molofsky

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6635

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie Molofsky
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman - Retired
11. Industry or business Tailor

FATHER
12. Name Leon Molofsky
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Gelbau
15. Birthplace Russia

16 (a) Informant Mr. Leonard Molofsky
(b) Address 3701 Overview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zion Cong.
Location Rosedale

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

VS SEP 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 3:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10:20 P.M 9/15 1948, to 3:20 AM 9/16 1948, and that I last saw h[im] alive on 9/16 1948.

Immediate cause of death Cerebral vascular ~~accident~~ embolism
R hemiplegia heart disease

Due to ~~Bronchopneumonia~~ (auricular fibrillation

Due to Cardiac insufficiency
Cardiac enlargement)

Other Conditions Sudamina bilateral
subcrepitant, moist

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration
12 hrs
unknown
5 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin L. Davis M.D.
Address W. Balto. Gen. Hosp. Date signed 9-16-48

Please write plainly, with pen and ink. Every question must be answered. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. Physicians are especially important.

666873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666873

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 213 Light St.

(c) Hospital or institution: So. Balto. Gen. Hosp. 21-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1271 Washington Blvd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henry L. Letcher

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Harriett E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	11	1		

9. Birthplace Massachusetts (Town, county and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER

12. Name Henry L. Letcher

13. Birthplace Canada

MOTHER

14. Maiden Name Unknown

15. Birthplace Massachusetts

16 (a) Informant Mrs Harriett E. Letcher

(b) Address 1271 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem.

Location 2930 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 904-03 N. Collins St

19 (a) SEP 16 1948 (b) Huntington Maryland (Registrar's record by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17, 1948, to 9-16 1948, and that I last saw h[im] alive on 9-16 1948.

Immediate cause of death: Cardiac failure — Duration

Due to Myocardial infarction

Due to Coronary occlusion — 36 hrs.

Other Conditions Mesenteric thrombosis

Aortic aneurysm abdominal

(Include pregnancy within 3 months of death)

Date of operation 9/11/48 + 9/11/48

Major findings of operation:

Carcinoma left colon & myocardial infarction

of autopsy: Abdominal aortic aneurysm

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Mary C. Letcher M.D.

Address 213 Light St. Date signed 9-17-48

VS 150

G66874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 S. Kenwood Ave.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma P. Nagler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George W. Nagler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	73 24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Bernard Hasse
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Musch
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 604 S. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Sept 1948, and that I last saw h alive on Sept 15 1948.

Immediate cause of death: Coronary Occlusion — Duration 2 hrs.
Due to: arteriosclerosis — 5 yrs.
Due to:
Other Conditions: Diabetes Mellitus; Arteriosclerosis; Duodenal Ulcer
(Include pregnancy within 3 months of death)
Date of operation DIVERTICULUM OF
Major findings of operation: DUODENUM
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGoy M.D.
Address 601 S. Ellwood Ave. Date signed 9/16/48

942

VS 150

Typewrite age as especially important. Physicians: please write the causes of death clearly and legibly.

G66875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G66875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT VINCENTI

3 (b) If veteran, name war ———

3 (c) Social Security Account No. 219-07-3133

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1899

8. AGE: Years (amt) 48 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace San. Clementi, Italy
(Town, county, and state)

10. Usual Occupation Garage Man

11. Industry or business American Brewery Garage

FATHER
12. Name Ferdinado Vivenzio
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Varone
15. Birthplace Italy

16 (a) Informant Reuben L. Uman (Lawyer)
(b) Address 110 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Moravia Ave.

18 (a) Funeral director Frank Della Noce
(b) Address SEP 16 1948 S. High Street

19 (a) (Date rec'd by registrar) (b) Huntington for Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948 1:35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull c Intra-Cranial Hemorrhage

Due to

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/14/48 at 12-30 A. M.
(b) Where did injury occur? In front of 1035 E. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Pistol

23. Signature Edward L. Kruger M.D.
Medical Examiner
Date signed 15 Sept 48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 931

Registered No. G66876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Gorsuch Ave
(c) Hospital or institution: 95

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Gorsuch
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John N. Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1857

8. AGE: Years	Months	Days	If less than one day
91	6	13	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Becker
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Jane McDermott
15 Birthplace Penna.

16 (a) Informant Mrs Myrtle Zeller
(b) Address 519 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Balt. St.

19 (a) SEP 16 1948 (Date received by Registrar) (b) Funeral Director for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 3.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 2 1948. to SEPT 15 1948. and that I last saw him alive on SEPT 14, 1948.

Immediate cause of death	Duration
Myocardial failure	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed Sept 15, 48

VS 150

6877

CERTIFICATE CORRECTED 9-1-56

JL - 118456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 666877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Street Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Hanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Brinkley
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Gashur
15. Birthplace Portugal

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germantown Rd

18 (a) Funeral director
(b) Address

19 SEP 17 1948 (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1948, at 7AM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1948 to Sept. 5 1948, and that I last saw her alive on Sept. 5 1948.

Immediate cause of death	Duration
Bronchogenic Carcinoma Rt upper lobe.	3 mo.
Due to	
Due to	
Other Conditions Generalized carcinomatosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A Nicholas Jr. M. D.
Address Balto City Hosp. Date signed 9 Sept 48.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County Long Island
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 89 Jason Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES JOSEPH DEVLIN

3 (b) If veteran, name war -

3 (c) Social Security Account No. 078-14-4399

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1897

8. AGE: Years 51 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace NY (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafarer

FATHER
12. Name James J. Devlin
13. Birthplace NY

MOTHER
14. Maiden Name Nellie Dwyer
15. Birthplace NY

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-48 (month) (day) (year)
(c) Cemetery or crematory New York City
Location New York

18 (a) Funeral director Edgeworth Funeral Corp.
(b) Address 3911 Liberty Heights Ave.

19 SEP 17 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Sept. 15 1948 and that I last saw him alive on Sept. 15 1948

Immediate cause of death 1- Postoperative state, excision duodenal diverticulum — Duration
Due to 2- Peritonitis, general
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9/13/48
Major findings of operation: Diverticulum of duodenum
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elton Moffett Jr.
Address US Marine Hospital Date signed 9/16/48

VS 199

66879

BC 48-19684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157M

Registered No. 66879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N. Payson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Mc Kinney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15 48

8. AGE: Years	Months	Days	If less than one day
—	—	—	hr. 20 min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas J. Mc Kinney
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mc Donnell
15. Birthplace Balto Md

16 (a) Informant Thomas J. Mc Kinney
(b) Address 243 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Ave

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Collins & Fremont Sts.

SEP 17 1948
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948 at 5 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1948 to Sept. 15 1948 and that I last saw h[illegible] alive on Sept. 15 1948.

Immediate cause of death — Duration
Heart Failure
Due to Anomalous blood vessels
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Smahler M. D.
Address Bon Secours Hosp Date signed 9/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 66660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~3 days~~ Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Apartments
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME (RANDIE) WILLIAM R. HUBNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-9172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Louise Schermer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) July 29, ~~1870~~ 1878

8. AGE: Years	Months	Days	If less than one day
70	1	18	— hr. — min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Hubner
13. Birthplace Germany

MOTHER
14. Maiden Name ~~Martin~~ ~~Hubner~~ Mary Harkin
15. Birthplace Baltimore, Md.

16 (a) Informant (Son) John R. Hubner
(b) Address Cambridge Apt., Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address 4905 York Road

19 (a) SEP 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Sept. 16 1948, and that I last saw him alive on Sept. 16 1948.

Immediate cause of death — **Duration**

Lymphosarcoma (generalized) — 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) (While at work?)
(e) Means of injury

23. Signature Eldred R. Bent
Address 33rd & Calvert Union Memorial Hospital
Date signed 9/16/48

VS 150

666881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 666881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1894

8. AGE: Years 54 | Months smt | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morsey
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Barnes
15. Birthplace Maryland

16 (a) Informant Violet Holt
(b) Address 2402 Woodbrook Ave Walbrook

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/48
(c) Cemetery or crematory New Cathedral Cemetery
Location Old Frederick Road

18 (a) Funeral director J. A. Brooks
(b) Address 1463 N. Carey St.

SEP 17 1948 (Date received by registrar) Funkhouser Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948 at 2.15 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Insnec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arterio-Sclerotic C.V.D.
Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

66688

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days) 16 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 LOCKRAVEN BLVD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS A. STADLER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 065-07-2889

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: MAY R. Stadler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1876

8. AGE: Years 72 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace MONTANA (Helena) (Town, county, and state)

10. Usual Occupation RETIRED Mining Engineer

11. Industry or business

FATHER
12. Name LOUIS STADLER
13. Birthplace Germany

MOTHER
14. Maiden Name MARY BOHLER
15. Birthplace MO.

16 (a) Informant WIFE
(b) Address SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sep 1948, at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sep 1948 to 16 Sep 1948, and that I last saw him alive on 16 Sep 1948.

	Duration
Immediate cause of death: CARCINOMA OF PROSTATE GLAND	3 YRS
Due to:	
Due to:	
Other Conditions: UREMIA — 6 WEEKS; TERMINAL PNEUMONIA 5 DAYS	

(Include pregnancy within 3 months of death)

Date of operation 7 Aug 48
Major findings of operation: CARCINOMA OF PROSTATE GLAND
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Ferris, M.D.
Address Mercy Hosp. Date signed 16 Sep 48

VS 150

66883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registration No. 66883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob E. Leister.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Thelma L. Leister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1890

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace: Hampstead, Md. (Town, county, and state)
10. Usual Occupation: Tavern
11. Industry or business: Self

FATHER
12. Name: Seymour Leister
13. Birthplace: Md.

MOTHER
14. Maiden Name: Lena ?
15. Birthplace: Md.

16 (a) Informant: Mrs. Vivian E. Fifer
(b) Address: Apt. 194, Edgewater Apts. Essex, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 17 1948 (Date rec'd by Registrar) (b) [illegible], Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1948, at 9a P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 15 1948, and that I last saw h[illegible] alive on Sept 15 1948.

Immediate cause of death	Duration
Myocardial infarction	
Due to Coronary thrombosis	
Due to Arteria-sclerotic H disease	
Other Conditions Adhesive pericarditis slight. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Those mentioned above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Howard Leicher M.D.
Address: West Baltimore Date signed: Sept 16, 1948

Gen Hosp

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Duncan St.
(c) Hospital or institution: 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ISIDOR GIBIAN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Gibian.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1872.

8. AGE: Years	Months	Days	If less than one day
75	9	19	hr. min.

9. Birthplace Checho-Slovakia. (Town, county, and state)
10. Usual Occupation Retired Tanner.
11. Industry or business

FATHER 12. Name ---------- Gibian.
13. Birthplace Checho-Slovakia.

MOTHER 14. Maiden Name Unknown.
15. Birthplace Checho-Slovakia.

16 (a) Informant Mrs. Helen Gibian,
(b) Address 702 N. Duncan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship.
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1902 E[illegible] Pl. [illegible], Md.

19 (Date received by registrar) SEP 17 1948 (Registrar's signature)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 16th. 1948 at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Sept 16 1948 and that I last saw Man alive on Aug 9 1948

Immediate cause of death Acute Cardiac Failure — Duration 15 mins.
Due to Arteriosclerotic Heart Disease — 5 yrs
Due to Generalized Arteriosclerosis — 10 yrs (approx.)
Other conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E. Monument St. Date signed 9/16/48

VS 150

666885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 E. 38th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country London, England

3 (a) FULL NAME Florence Henry de Pothonier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1863

8. AGE: Years 84 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Henry de Pothonier
13. Birthplace England

MOTHER
14. Maiden Name Jane C. Duncan
15. Birthplace England

16 (a) Informant Mrs. A. Phillips
(b) Address 334 Rossiter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winfield
(b) Address 900 East Biddle St

SEP 17 1948 (Date rec'd by registrar) (b)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948 at 9.20 p M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946 to Sept 1948 and that I last saw him alive on Sept 16 1948.

Immediate cause of death: Arteriosclerotic Cardio-vascular Disease — Duration: Many years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. V. D. Mack M. D.

Address 513 E. 39th St Date signed 9.5.48

45

X

Author's written signature, with occupation and address, must be on file in office where record is filed. Every item must be answered; if information cannot be obtained, state "unknown." Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that your answer to each question is complete and correct. Omit no items. If deceased was a child or infant, the exact age is especially important.

666886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 666886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Lorman Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Lorman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE FLOYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1913

8. AGE: Years: 35 | Months: 6 | Days: 13 | If less than one day: hr. min.

9. Birthplace Hartsville S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Aaron Floyd.
13. Birthplace Hartsville, S. C.

MOTHER
14. Maiden Name Julia Richardson.
15. Birthplace Hartsville S.C.

16 (a) Informant: James Johnson
(b) Address 1803 Lorman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 3-32 N. Edmondson Ave.

19 (a) SEP 17 1948 (b)
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1948, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Hypertension - Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
(e) Signature Carl L Royer M.D.
Medical Examiner
Date signed 9-15-48

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS 151

666887

AB-121493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 666887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Smithson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Waters.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1- 1887

8. AGE: Years	Months	Days	If less than one day
61	5	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Eugene Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Bruce
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/48 (month) (day) (year)

(c) Cemetery or crematory Randallstown
Location Randallstown, Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1013 Runtzman St

19 SEP 17 1948 (a) (b) Kingsley MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1948 at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22- 1948 to 9-13- 1948, and that I last saw him alive on 9-13- 1948.

Immediate cause of death Coronary thrombosis

Due to Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8/31/48

Major findings of operation: Perineal abscess

of autopsy:

Duration
5
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman Cole M.D.
M. D.
Address 4940 Eastern Ave Date signed 16 Sept 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. G66888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Jessup (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Blanche Crone

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Husband - Charles | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-19

8. AGE: Years 29 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Etle
13. Birthplace Md.

MOTHER
14. Maiden Name Madeline Zinkhand
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1948 (month) (day) (year)
(c) Cemetery or crematory St Lawrence Cemetery
Location Jessup, Maryland

18 (a) Funeral director DeWitt Donaldson
(b) Address Laurel, Maryland

19 (a) SEP 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948 to 9-15 1948 and that I last saw her alive on 9-15 1948.

Immediate cause of death Cardio-Respiratory failure - | Duration

Due to Chronic glomerulonephritis & uremia -

Due to & Hypertension - Ot.

Other Conditions decline

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Venable Jr MD M. D.
Address St Agnes Hosp. Date signed 9-15-48

VS 150

G66889.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+ 1179

✓ G66889 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Catons

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 305 N. Bradenwood (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Henry Rackemfeger ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or wife~~ Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-78

8. AGE: Years	Months	Days	If less than one day
70	4	2	hr. 1 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Daniel - dec'd

13. Birthplace Germany

MOTHER 14. Maiden Name Fanny Arnold (dec'd)

15. Birthplace Md

16 (a) Informant Henry Rackemfeger

(b) Address 305 N. Bradenwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo. A. Farley

(b) Address Catonsville Md

19 (a) Date received by Local Registrar Sept 17 1948 (b) Registered by

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1948, to 9-15 1948, and that I last saw h alive on 9-15 1948.

Immediate cause of death Emphysema — Duration

Due to Pneumonia, — Duration

Due to Bleeding Peptic Ulcer — Duration

Other Conditions — Duration

(Include) pregnancy within 3 months of death.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul A. Dreyer Jr. M. D.

Address St. Agnes Hosp. Date signed 9/17/48 ✓

666890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666890

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 47 Kennedy Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey C. Gaither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Virgie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1889

8. AGE: Years	Months	Days	If less than one day
59	5	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Construction Co.

FATHER
12. Name Harvey C. Gaither
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Carey
15. Birthplace Md.

16 (a) Informant Mrs. Virgie Gaither
(b) Address 47 Kennedy Lane

17 (a) Burial (b) Date thereof 9-20-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

19 (a) SEP 17 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sept. 1948 at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 16 Sept. 1948

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C66891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. C66891

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Gorsuch St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin H. Rozan Sr.

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Teresa Rozan.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6.

8. AGE: Years: 57 | Months: 1 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Theater Manager.

11. Industry or business:

FATHER
12. Name: John Rozan
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Conway
15. Birthplace: Maryland

16 (a) Informant: Teresa Rozan.
(b) Address: 1401 Gorsuch St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 20-1948 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: Flynn-Fleming
(b) Address: 1426 Light St.

19 (a) SEP 17 1948 (Date filed by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948, at 5:50 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/12/ 1948 to 9/16/ 1948, and that I last saw him alive on 19

Immediate cause of death
(a) Gastric hemorrhage
(b) Cerebral thrombosis
Due to Acute gastritis with multiple ulcers and erosion.
Due to Generalized arteriosclerosis
Other Conditions Diabetes Mellitus

Duration: about 6 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See under # 21

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Fleming M.D.
Address 1319 Light St. Date signed 9/16/48

836

666892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. 666892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Appleton Street
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Appleton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison Jackson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1922

8. AGE: Years	Months	Days	If less than one day
26	-	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Harrison Jackson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Effie Vessels
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Effie Baylor
(b) Address 1814 Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 18- 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Maryland

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 Mcculloh Street

19 (a) Filed Sep 19 1948 (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948 at 1.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12/1948 to 9/16 1948
and that I last saw h alive on 9/15/1948

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to T.B.C.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1300 N. Grant St Date signed 9/17/48 M. D.

VS 150

666893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93c ✓

Registered No. 666893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Madison Ave.
(c) Hospital or institution: Bar-Wil- Ba Convenience Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Fitting Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie V. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 4, 1869

8. AGE: Years	Months	Days	If less than one day
78	10	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Tabb
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lavinia Mars
15. Birthplace Baltimore, Maryland

16 (a) Informant Carlse B. Patterson
(b) Address 222 Fitting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 862 Madison ave.

19 (a) Filed SEP 17 1948 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Sept 15 1948 and that I last saw her alive on Sept 15 1948

Immediate cause of death Chronic Arthritis — Duration 2 yrs.

Due to Cardio Vascular Disease — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury

23. Signature William Frey M.D.
Address 1928 Penna Ave Date signed Sept 16/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 6668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

541

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GREENWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 16 1948

18 (a) Funeral director [illegible]
(b) Address

19 SEP 17 1948 (b) [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (White or Negro)
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 9-3-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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66895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No.: Sherman Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Baby Girl Reynolds

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-12-48

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace: University Hospital (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER — 12. Name: Alexander Mitchell
13. Birthplace:

MOTHER — 14. Maiden Name: Doris Mae Reynolds
15. Birthplace:

16 (a) Informant: Mother
(b) Address: Sherman Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: SEP 17 1948

18 (a) Funeral director
(b) Address

19 SEP 17 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-16- 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948, to 9-16 1948, and that I last saw her alive on 9-16 1948.

Immediate cause of death: Prematurity

Duration:

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify to person of place)
(e) Means of injury:

23. Signature: P a Peterson M. D.

Address: University Hosp Date signed: 9-16

G66896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G66896

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County CALVERT
(c) City or town OWINGS (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. Yes or No
If yes, name country

3 (a) FULL NAME BARBARA ELLEN KRATZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 3, 1932

8. AGE: Years	Months	Days	If less than one day
16	6	13	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation STUDENT
11. Industry or business

FATHER
12. Name WILLIAM S. KRATZ
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name Edith OWINGS
15. Birthplace Md. (Calvert Co.)

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Friendship Meth. Cem.
Location Friendship, A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 16 1948 at 7:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-16 1948. and that I last saw HER alive on 9-16 1948.

Immediate cause of death Brain tumor
Due to (Craniopharyngioma)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 15 Sept 1948
Major findings of operation: Brain tumor
of autopsy: Brain tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H. K. Silver M. D.
Address Johns Hopkins Date signed 9/17/48

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 666897

GM 121439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Whitbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Francis Kelly

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W.

6 (b) Name of husband or wife Mary Ann Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1862

8. AGE: Years	Months	Days	If less than one day
85	10	13	hr. min.

9. Birthplace MD. (Baltimore) (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Thomas H. Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McCabe
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 17 19[illegible] (Date rec'd by registrar) (b) Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 19 48, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 30- 19 48, to 9-16- 19 48, and that I last saw him alive on 9- 16- 48.

Immediate cause of death Uremia — Duration Wks

Due to Chronic Renal failure — Months

Due to Generalized Arteriosclerosis — Yrs

Other Conditions Gangrene R foot — 2 wks

(Include pregnancy within 3 months of death)

Date of operation 8-10-48

Major findings of operation: Gangrene R foot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myles A Pinkston MD M. D.
Address Baltimore City Hosp Date signed 9-16-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66898 JL -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Byrd -Ophelia

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Ophelia Moses
15. Birthplace ?

16 (a) Informant E. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year) 9 AM
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern ave

18 (a) Funeral director B C H. Crematory
(b) Address

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948, at 10.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1948 to Sept. 13 1948, and that I last saw him alive on Sept. 13 1948

Immediate cause of death: Prematurity — Duration: 36 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fetal atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Toms M. D.
Address Date signed Sept. 18

BC-48-17288

66899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G66899

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt - 37
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Frank Kaczorowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-10-48

8. AGE: Years	Months	Days	If less than one day
	1	738	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name James Gregg Kaczorowski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Veronica Wojcik
15. Birthplace Baltimore, Md.

16 (a) Informant Birth certificate
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) [illegible] Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1948, at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1948 to 9-17 1948, and that I last saw him alive on 9-17 1948.

Immediate cause of death Cardiac failure — Duration

Due to Congenital Heart Disease Probably Interventricular

Due to Septum

Other Conditions

(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address University Hospital Date signed 9-17-48 M.D.

VS 150

166900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 166900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 Argonne Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles L. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-2208

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-86

8. AGE: Years	Months	Days	If less than one day
61 62	8	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Kenneth Fowler
13. Birthplace ?

MOTHER
14. Maiden Name Lucy ?
15. Birthplace ?

16 (a) Informant Kenneth Fowler (son)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 — 1948 at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10-1948 to 9-16-1948, and that I last saw him alive on 9-16-1948.

Immediate cause of death Cardiac failure

Due to Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mitral & aortic stenosis, mural thrombus, lung and kidney

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn M. Judd M. D.
Address Mercy Hosp Date signed 9-16

VS 199

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. 66901

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pulaski & Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EISENACHER, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-28 3806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1931

8. AGE: Years	Months	Days	If less than one day
17	3	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Apprentice
11. Industry or business Brush Maker

FATHER
12. Name Charles M. Eisenacher, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret M. Walters
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret M. Eisenacher
(b) Address 205 S. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto & B. M. Walters

18 (a) Funeral director Roth & Sticklefts
(b) Address

19 (a) SEP 18 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948, at 9:17 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Bullet wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 16/48 7:30 P.M.
(b) Where did injury occur? 205 S. Pulaski St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury firearms

23. Signature Medical Examiner. M.D.
Date signed 17 Sept 48

VS 151

666902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 111c

Registered No. 666902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Lamont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHIRLEY ANN (SHAFFER) SHAFFER djm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1939

8. AGE: Years	Months	Days	If less than one day
9	6	4	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles N. Shaffer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha M. Reed
15. Birthplace Md.

16 (a) Informant Martha M. Shaffer
(b) Address 1738 Lamont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948, at 9.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema of brain
Edema of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (White or Black)
(d) Means of injury

23. Signature George H. Pierce M.D. Medical Examiner.
Date signed September 16, 1948

VS 151

Correct age in especially important. Physicians: please write the cause of death clearly and legibly.

66903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Charolett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA Isabelle SCHELLENSCHLAGER

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mathias

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1891

8. AGE: Years 57 | Months 3 | Days 2 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Constance
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Ellen V. Gordon
15. Birthplace: Baltimore, Maryland

16. (a) Informant: Eva Ellen Schellenschlager
(b) Address: 1604 Charlott Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20,48 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge Memorial
Location: Dorsey, Maryland

18 (a) Funeral director: William Cook, Inc.,
(b) Address: 1217 St. Paul Street

19 Filed SEP 18 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948 at 12.05 A M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Congestive Heart Failure

Due to: Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogge M.D.
Medical Examiner.
Date signed 9-18-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles Street
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 354 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Pearl Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife Christian Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) FEB 18, 1896

8. AGE: Years 52 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business Self

FATHER 12. Name Louis Jones
13. Birthplace Kentucky

MOTHER 14. Maiden Name Rich
15. Birthplace Kentucky

16 (a) Informant Helen Rogers
(b) Address 354 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director John Cook Inc.
(b) Address 1217 St Paul St.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Burial permit issued Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17/48 19 . at 7:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 19 48 to Sept 17 1948 and that I last saw h alive on Sept 17 1948

Immediate cause of death: Acute Heart Failure — Duration 2 days

Due to myocardial degeneration 1 yr

Due to arteriosclerosis —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John A Glass M. D.
Address 816 Cathedral Date signed 9/17/48

VS 150

66905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Maude Lilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Husband - Floyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-17-1876

8. AGE: Years 72 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Brethyon
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Mrs Emily Phelps
(b) Address 2209 N Gaitongall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Howard County

18 (a) Funeral director E. C. Higinbotham
(b) Address Ellicott City Md

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Turrington-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13-48 to 9-15-48.
and that I last saw her alive on 9-15-48

Immediate cause of death Tracheal Edema

Due to Self-inflicted wound.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/13/48

Major findings of operation: Tumor of trachea (partial)

of autopsy: Tracheal edema

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Suicide
(b) Date of occurrence 9/13/48 at 5 P M
(c) Where did injury occur? Ellicott City (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work?
(e) Means of injury RAZOR

23. Signature Stephen H. Fromm M. D.
Address St. Agnes Hospital Date signed 9-16-48

Certified for Dr. Wm. Helfrich by Thomas J. Madden, M.D.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

66906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 66906

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution:
(D.O.A.) University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Aloysius McShane

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 215-10-0873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen K. McShane
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March-19-1889

8. AGE: Years	Months	Days	If less than one day
59	5	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Revere Copper & Brass Works

FATHER
12. Name John F. McShane
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary J. Affayroux
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Helen K. McShane (wife)
(b) Address 2804 Erdman Ave., City #13

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept-20-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City #1

SEP 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1948, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Exo death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kamma Jr. M.D. Medical Examiner.
Date signed 17 Sept. 48

VS 191

666907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. 666907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 S. Collins Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Collins Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mungo Duncan Wyper

3 (b) If veteran, name war —

3 (c) Social Security Account No. 169-07-2213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Janet S. Wyper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1901

8. AGE: Years	Months	Days	If less than one day
47	5	14	hr. min.

9. Birthplace Galston, Scotland
(Town, county, and state)
10. Usual Occupation Mustard Miller
11. Industry or business McCormick & Co.

FATHER
12. Name Robert L. Wyper
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Duncan
15. Birthplace Scotland

16 (a) Informant Mrs. Janet S. Wyper
(b) Address 508 S. Collins Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Easton Lane
(b) Address Ellicott City, Md.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington McQuigg M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948; at 3.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 July 1948 to 16 Sept 1948, and that I last saw him alive on 15 Sept 1948.

Immediate cause of death Pulmonary silicosis — Duration 5 yrs +

Due to

Due to

Other Conditions Pulmonary tuberculosis?? — 1-2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 20 E. Preston St. Balt. Date signed 17 Sept 48

VS 150

G66908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G66908

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave & Dukeland St

(c) Hospital or institution: West Baltimore General Hosp. 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1313 Wilcox
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mrs. Ozane Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George M. Watson

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) March 25, 1891

8. AGE: Years	Months	Days	If less than one day
57	5	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name John Nixon

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Ozane Busby

15. Birthplace Baltimore Md.

16 (a) Informant George M. Watson

(b) Address 1313 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location East End of North Ave.

18 (a) Funeral director Charles McCollin

(b) Address 924 E. Eager St.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1948, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948, to 9/16 1948; and that I last saw h[illegible] alive on 9/16 1948.

Immediate cause of death	Duration
Cardiac failure	
Hypertensive Cardiovascular dis	
Due to Uremia	
Due to Nephrosis (sulfa toxicity)	
Glomerulonephritis	
Other Conditions Arteriosclerotic heart dis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address West Balto Gen Hosp Date signed 1-17-49

666909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 666909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Lafayette Ave & John St
(c) Hospital or institution:
Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 34 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Loretta Bowen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband ~~or wife~~ W. J. Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24, 1865

8. AGE: Years 82 | Months 9 | Days 24 | If less than one day 23 hr. min.

9. Birthplace Towson Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Westley German
13. Birthplace Not Known

MOTHER
14. Maiden Name Alia Bowen
15. Birthplace Not Known

16 (a) Informant Son, W. J. Bowen
(b) Address Box 34 Cockeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-1948 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md

18 (a) Funeral director John Byrne Sons
(b) Address 610 York Rd Huntington Station Baltimore, Md

19 SEP 13 1948 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948 at 9:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 17 1948, to 19..., and that I last saw ~~him~~ her alive on Sept 17 1948.

Immediate cause of death Peritonitis — Duration

Due to Carcinoma of Cecum —

Due to

Other Conditions Fibroid Uterus
Senile arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of Cecum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mark E. Hall, J M. D.
Address Women's Hospital Date signed 9/18/48

VS 150

66910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

66910 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Holehan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Duena V. Holehan 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4th 1876

8. AGE: Years	Months	Days	If less than one day
72	6	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Field Deputy
11. Industry or business Internal Revenue Dept.

FATHER 12. Name John E. Holehan
13. Birthplace England

MOTHER 14. Maiden Name Margaret B. (Unknown)
15. Birthplace Ireland

16 (a) Informant Duena V. Holehan
(b) Address 2015 St. Paul St.

17 (a) Burial (b) Date thereof Sept 20 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave Ext

18. (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 18 1948 (b) Thomas Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16th 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 16 1948, and that I last saw h in alive on Sept 16 1948.

Immediate cause of death	Duration
Cerebral thrombosis	4 days
Due to Arteriosclerosis &	
Due to Chronic Myocarditis	1 year
LEUKOPLAKIA	
Other Conditions Leukoplakia of Mouth.	1 year
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elbert Mortimer Jr. Md M. D.
Address 2706 St Paul St Date signed 9/18/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 66911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Loudon Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2834 Guilford Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARY WERNER FAIR

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Dr. Horace L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Publistenographer
11. Industry or business Self

FATHER
12. Name George P. Werner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name A. M. Ingram
15. Birthplace Virginia

16 (a) Informant George Werner
(b) Address 2 East Lexington St.

17 (a) Burial (b) Date thereof Sept. 20, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 18 1948 (b) Huntington Pharmacy Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1948, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept 16 1948 and that I last saw h alive on Sept 16 1948.

Immediate cause of death Cerebral hemorrhage — Duration 12 hours
Arterio-sclerosis — 3
Due to Cardiac hypertrophy — 3
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. H. Jones M.D.
Address 2818 St. Paul Date signed 9/17/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

66912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66912

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL EDMONDS (SAMUEL WARING EDMONDS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, (widowed) or divorced. Widower

6 (b) Name of husband or wife Catherine Connolly Edmonds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1866

8. AGE: Years 81 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Edmonds
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Julia Pouder
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Charles Moyer Gardiner
(b) Address 3031 St. Paul street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 418 N. Mt. Royal Ave

19 SEP 18 1948 Registrar of Vital Statistics, Baltimore, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948, at 1.00 A.M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull & intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/2

(a) Date of injury 9-16-48 at approx. 12.00 P. M.
(b) Where did injury occur? 3031 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell down steps

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-2-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33d and Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Riderwood, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sherwood Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Leland Sebald

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 318-03-3660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Elsie L. Sebald

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	0	15		

9. Birthplace Illinois (Chicago)
(Town, county, and state)

10. Usual Occupation: Vice President
11. Industry or business: Commercial Credit Co.

MOTHER / FATHER
12. Name Benno William Sebald
13. Birthplace Plymouth, Wisc.

MOTHER
14. Maiden Name Harriet E. May
15 Birthplace Watertown, Wisc.

16 (c) Informant Mr. Leslie E. Sebald
(b) Address Ridgewood, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 18 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 – 17 1948 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948 to 9-17 1948 and that I last saw him alive on 9-17 1948

Immediate cause of death: Pulmonary edema and shock — Duration

Due to: Coronary Occlusion

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Benson, Jr., M. D.
Address 33d & N. Calvert Date signed 9-17-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66914

1219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JANE GRANT

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 8, 1864

8. AGE: Years 83 | Months 9 | Days 9 | If less than one day hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Michael J. Grant
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Haney
15. Birthplace Ireland

16 (a) Informant Mrs. Howard Sanders
(b) Address 4411 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Reg.) (b) Huntington McGuinness, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1948 at 4:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 17 1948, and that I last saw her alive on Sept 16 1948.

Immediate cause of death	Duration
Uraemia	5 d
Bronco Pneumonia (DECUBITUS)	2 d
Due to Mitral Regurgitation (HYPERTENSION) Arteriosclerosis	14 d
Due to Chronic Interstitial Nephritis (NEPHRITIS)	14 d
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Stevens M.D.
Address 2878 Harford Ln Date signed 9-17-48

VS 150

PLEASE WRITE PLAINLY, with pen and ink. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124R

Registered No. 66915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence E. Burgess

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 18th 1887

8. AGE: Years 61 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Embalmer

11. Industry or business John J. Cowan & Son

FATHER 12. Name John H. Burgess

13. Birthplace Laurel Md

MOTHER 14. Maiden Name Sarah A. Mason

15. Birthplace Washington D.C.

16 (a) Informant Mrs Anna M. Burgess

(b) Address 208 S. Gilmor, Lft.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St

SEP 18 1948 Baltimore, Md. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17th 1948 at 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 17 1948. and that I last saw h[illegible] alive on Sept 17, 1948

Immediate cause of death Respiratory Failure — Duration: Several days

Due to Passive Congestion — Duration: Several yrs.

Due to Chron. Myocarditis and Cirrhosis of Liver — Duration: Several yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.

Address 206 S. Gilmor St Date signed Sept 18, 48

VS 153

X

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

66916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 66916

LcH 119120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME JAMES HAMBERRY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Annie L.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1879

8. AGE: Years	Months	Days	If less than one day
68	11	4/14	hr. ..... min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B-O R.R.

FATHER
12. Name Martin Hamberry (d)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Birmingham (d)
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Laurel (b) Date thereof 9/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gwynn Son
(b) Address 901-03 Hollins St.

SEP 18 1948 (b) Remington-Baltimore, Md.
(Date rec'd by registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22/48 19 .. to 9/16 19 48 and that I last saw h im alive on 9/16 19 48.

Immediate cause of death Hemorrhage — Duration 2 days
Due to Carcinoma of Bladder — ?
Due to .....
Other Conditions .....
(include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: Ca Bladder, Central edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J. Cole M.D. M. D.
Address 4940 Eastern Ave Date signed 9-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66917 Wood

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

Registered No. 66917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1266 Sargent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WOOD (mp)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Mary M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1907

8. AGE: Years	Months	Days	If less than one day hr.	min.
40	9	15		

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Columbia Florist

FATHER
12. Name George Wood
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace Scotland

16 (a) Informant Mrs Mary M. Wood
(b) Address 1266 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) SEP 18 19 (Date rec'd by registrar) (b) Interment Burial, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948 at 1.55 A M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous Subarachnoid Hemorrhage
Due to Hypertensive C.V. Disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 17 Sept 48

VS 131

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66918
AB-122736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

66918
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Paca St. (Nursing Home)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Throphalus Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife. ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11- 1871

8. AGE: Years 77 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John Kelly (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Lizzie Webb (D
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Jesus
Location Hernandez Hill Rd.

18 (a) Funeral director Charles S. Quilici
(b) Address 901 S. Conkling St.

19 SEP 18 1948 (Date rec'd by registrar) Huntington Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7- 1948 at 6.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6- 1948 to 9-7- 1948 and that I last saw him alive on 9-7- 1948

Immediate cause of death — Duration
Acute heart failure
Due to Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Tuberculosis of lungs, far advanced

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. P. Telfer M.D. M. D.
Address Balto City Hosp Date signed 9-17-48

VS 130

666919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

666919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS Wesley POPE

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1924

8. AGE: Years: 24 | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or Business

FATHER 12. Name Rev. Leroy Pope

13. Birthplace Va.

MOTHER 14. Maiden Name Lucy Brunell

15. Birthplace Va.

16 (a) Informant Rev. Leroy Pope

(b) Address 1928 Riggs Ave.

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 9-18-48

(c) Cemetery or crematory Franklin, Va.

Location

18 (a) Funeral director W. Hall Fitzgerald

(b) Address 918 [illegible]

19 SEP 18 1948 (b) [illegible]
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1948, at 4 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull - Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-7-48 at 9:05 P.M.

(b) Where did injury occur? Rear of 1001 W. Fayette St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Blunt force

23. Signature [signature] M.D.
Medical Examiner

Date signed 9-18-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G66920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Since

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 No. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1899

8. AGE: Years 48 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Buckingham Co. Va
(Town, county, and state)

10. Usual Occupation Ice man

11. Industry or business

FATHER 12. Name Frank Carter

13. Birthplace Va.

MOTHER 14. Maiden Name Olivia Payne

15. Birthplace Va.

16 (a) Informant Mrs. Edmond Lawson

(b) Address 1106 Stricker St. Balto. Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 22 1948 (month) (day) (year)

(c) Cemetery or crematory Buckingham, Va.

Location Buckingham, Va.

18 (a) Funeral director Geo. L. Nelson

(b) Address 1505 Pennsylvania Ave.

SEP 19 1948 (Date rec'd by Registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1948 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948, to 9-17 1948, and that I last saw him alive on 9-18 1948.

Immediate cause of death Septic intoxication Duration

Due to Liver damage possible carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan H. Bickley, M.D.

Address 601 No. Calhoun St. Date signed 9-18-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66921 | 66921 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fern Inn Road
(c) Hospital or institution: Univ. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME William C Bulbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Laura Virginia Bulbert | 6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr) Feb. 17 1881

8. AGE: Years	Months	Days	If less than one day
67	7	1	hr. min.

9. Birthplace Carroll Co., Md (Town, county, and state)
10. Usual Occupation Carpenter, Painter
11. Industry or business Grocer,

FATHER
12. Name David Bulbert
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Ida M. Patrick
15. Birthplace Maryland

16 (a) Informant Mrs. Laura Bulbert
(b) Address Manchester Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Manchester Md

18 (a) Funeral director Jacob Windis (Sons)
(b) Address Manchester Md

19 SEP 19 1945 (Date received by Registrar) (b) Registrar

Huntington Hollinger, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1945 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 9-18 1945 and that I last saw him alive on 9-18 1945

Immediate cause of death Coronary Thrombosis — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Howard E Hall, M.D.
Address Univ. Hosp Date signed 9/19/45

6422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666922 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE K. TATE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1883

8. AGE: Years	Months	Days	If less than one day
65	5	6	hr. min.

9. Birthplace Westmoreland Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Kelly
13. Birthplace Westmoreland Cp. Va.

MOTHER
14. Maiden Name Lucy Reid
15. Birthplace Westmorsland

16 (a) Informant William Tate
(b) Address 1535 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

SEP 19 1948 Huntington, Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1948 to Sept. 15, 48 and that I last saw her alive on Sept. 15 1948

Immediate cause of death — Duration

Congestive heart failure — 6 weeks

Due to

Due to Hypertensive Card-Vas dis. — Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M. D.
Address 844 N. Carey St. Date signed 9/13/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66923 Registered No. 832

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Cantor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Rev Harry Cantor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Aaron Jacob Adelman
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude
15 Birthplace Russia

16 (a) Informant Miss Anna Cantor
(b) Address 3514 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Degel Israel Cemetery
Location Lancaster Penn.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

SEP 19 1948 (Date rec'd by Registrar) (b) Washington Wilkinson MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14/48 19 . at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 . to 9-14 1948.
and that I last saw her alive on 9/18 1948.

Immediate cause of death Cerebral Thrombosis — Duration 4 days
Due to Arteriosclerosis
Coronary atherosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meyer Bolton M. D.
Address 3320 Auburn Date signed 9-14-48

VS 159

BC-B 74619
666924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122B

Registered No. 666924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Washburn Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Acron Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1943

8. AGE: Years	Months	Days	If less than one day: hr.	min.
5	4	18		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name James Wesley Ford, Jr.
13. Birthplace Belton, Md.

MOTHER
14. Maiden Name Lillian Pierce
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mrs. Lillian Ford (mother)
(b) Address 500 Washburn Ave., Balto 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon. Sept. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director H. Leonard Evans
(b) Address 400 E. Chase St. Balto 39 Md.

19 (a) SEP 19 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948, at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/ 1948, to 9/16/ 1948, and that I last saw him alive on 9/16/48 19

Immediate cause of death: Cerebral edema
Due to: Cause pending
Due to:
Other Conditions: Intussusception
(Include pregnancy within 3 months of death)

Date of operation Sept 13 + 16th, 1948
Major findings of operation: Intussusception
of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Wallenmeyer M. D.
Address St. Joseph. Hospital Date signed 9/17/48

VS 199

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66925

BALTIMORE CITY HEALTH DEPARTMENT ✓ 46E

CERTIFICATE OF DEATH

Registered No. G66925

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution:
Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Willey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-7650

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 23 Jul 1900

8. AGE: Years	Months	Days	If less than one day
48	1	13	24 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Ship yard worker (Fireman)

11. Industry or business Beth. Steel Corp.

FATHER
12. Name William Willey
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Lena SMITH
15. Birthplace Balto. Md.

16 (a) Informant Edw. L. Willey (Bro.)
(b) Address 1409 Battery Ave, Balto 39 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 19 Sept 20 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location B. C. Co., Md.

18 (a) Funeral director C. H. Bamond Funeral Home
(b) Address 1600 E. Chase St. Balto 39

19 SEP 19 1948 (Date rec'd by registrar) (b) [signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sep 1948, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Sep 1948 to 16 Sep 1948, and that I last saw him alive on 16 Sep 1948.

	Duration
Immediate cause of death Shock and Toxemia	1 hr.
Due to Intestinal obstruction	2 wks.
Due to Carcinoma, annular, of sigmoid & liver metastases	months.
Other Conditions Multiple polyposis & diverticulae of colon	years

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation autopsy / Ruptured diverticulum @ cecum; pneumonia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph V. Calogno M. D.
Address Franklin Sq. Hosp. Date signed 16 Sep 48

VS 159

G66926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G66926 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Walkers + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 S. Calhoun St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Edward Gates

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-10-4084

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wife - Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-1879

8. AGE: Years 69 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business B&O R R

FATHER 12. Name John

13. Birthplace Md.

MOTHER 14. Maiden Name Virginia Robinson

15. Birthplace Md.

16 (a) Informant MRS LILLIAN GATES

(b) Address 2 S CALHOUN ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 21 '48 (month) (day) (year)

(c) Cemetery or crematory LORRAINE

Location WOODLAWN, MD

18 (a) Funeral director Harry A Wyche

(b) Address 4101 Edmondson Ave

19 (a) Filed (b) Recorded by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 11:40 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 9-14 1948 to 9-17 1948 and that I last saw h[illegible] alive on 9-17 1948.

Immediate cause of death: Cardio-respiratory failure — Uremia

Due to Severe gastro-intestinal hemorrhage

Due to peptic ulcer

Other Conditions Arterio-sclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As Above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. J. Venable Jr. M.D.

Address St. Agnes Hospital Date signed 9-17

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Franklintown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie F. Manger.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Wm. H. Manger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1882

8. AGE: Years	Months	Days	If less than one day
66	1	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Late August Feuerherd
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Murbach
15. Birthplace Germany

16 (a) Informant Mr. Leroy A. Manger
(b) Address 124 S. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd.

18 (a) Funeral director Harry K. Tuttle
(b) Address 4101 E. Lombard Ave.

19 I (a) [illegible] (b) [illegible] by registration with me. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1945 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 16 1945. and that I last saw h alive on Sept 16 1945.

Immediate cause of death Coronary Occlusion (Intrinsic) of Left Ventricle of Heart — Duration 1 yr.

Due to Arteriosclerosis of Aorta — Duration 2 yrs.

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 720 W Mt. Rd. Date signed 9/17/45

VS 150

G66928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

✓ G66928

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Penrose Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Carney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Owen B. Carney, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Anthony Hofstetter
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Veith
15. Birthplace Md.

16 (a) Informant Mr. Owen B. Carney
(b) Address 1806 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry N. Lutzke
(b) Address 4101 Edmondson Ave.

SEP 19 1948
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16/48. 19 at 12 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Sept 16 1948.
and that I last saw her alive on Sept 16 1948.

Immediate cause of death: Carcinoma of the Oesophagus with metastases. — Duration ? ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 1109 St Paul St Date signed 9/17/48

Baltimore Md

VS 150

X

666929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 666929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude J. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	19	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Owen Connor
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Sullivan
15. Birthplace Ireland

16 (a) Informant Mr. Robert M. Miller
(b) Address 10 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Luitzke
(b) Address 4101 Edmondson Ave.

SEP 20 1948 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Sept 17 1948 and that I last saw h alive on Sept 17 1948.

Immediate cause of death Carcinoma of head & pancreas. — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/2/48

Major findings of operation: Carcinoma of head & pancreas

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Stillman M. D.

Address 6 E Biddle St Date signed 9/10/48

666930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 666930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Wenth
(c) Hospital or institution University Hospital 5 West
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 803 N Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leo F. Adams Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-6615

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1902

8. AGE: Years 46 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation miller

11. Industry or business Black & Decker Co.

FATHER
12. Name Benj F. Adams
13. Birthplace Pa

MOTHER
14. Maiden Name Amelia (Unknown)
15. Birthplace Pa.

16 (a) Informant Hilda adams.
(b) Address 803 N. Calvert st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul st.

SEP 20 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/48 19 ... at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 19 48 to 9/18 1948.
and that I last saw h/m alive on 9/18 19 48.

Immediate cause of death Respiratory failure

Due to Carcinoma Lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature Joseph O'Hara M.D.
Address [illegible] Date signed 9/18/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1279

Registered No. G66931

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert streets

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 628 East 31st Street
(If rural give location)

(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME Franklin Eugene Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife MRS. KATHERINE E. Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1870

8. AGE:

Years	Months	Days	If less than one day
78	4	24	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Andrew J. Bell

13. Birthplace Maryland

MOTHER

14. Maiden Name Elizabeth Ellen Watkins

15. Birthplace Maryland

16 (a) Informant Union Memorial Hosp. Records

(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Baltimore Md

18 (a) Funeral director Wellington Cook Inc

(b) Address 17 N. St. Paul St.

19 (a) SEP 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1948 at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1948, to Sept 18 1948, and that I last saw him alive on Sept. 18, 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 9, 1948.

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)

(e) Means of injury

23. Signature J. Frank Supplee M.D.

Address Union Memorial Hosp Date signed Sept 5, 48

VS 150

BROOME

666932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

666932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Baltimore Hosp 12 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write the name of county and the town)
(d) Street No. 3214 Abell ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rodger Broome

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Myrtle E Broome

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1875

8. AGE: Years 69 | Months 11 | Days 10 | If less than one day hr. min. 3

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Cumberland Coal Co

FATHER 12. Name Roger G. Broome

13. Birthplace Virginia

MOTHER 14. Maiden Name Nannie

15. Birthplace Virginia

16 (a) Informant Myrtle E Broome

(b) Address 3214 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Milligan Cook Inc

(b) Address 1017 St Paul St

19 SEP 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Sept 1948 at 3:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to Inspection or Inquiry death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Antecedent

Due to

Other Conditions Coronary sclerosis

Fract. left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing X cause of death, fill in the following:

(a) Date of injury 9-1-48 at approx. 11.00 A.M.

(b) Where did injury occur? Carvel Beach, A.A.C.

(c) Did injury occur at home, on farm, industrial place, in public place? Neighbor's back yard While at work? No

(d) Means of injury Struck by tree

23. Signature Emil Rogers M.D. Medical Examiner

Date signed 12 Sept 48

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure that every item is correct and complete. Answer all questions. Where none, or not applicable, write "None." Do not abbreviate. Use extra sheet if necessary. Be sure that cause of death is correct and complete. Physicians: please write the causes of death clearly and legibly. Cause of death may not be entered as "heart failure," "asthenia," "exhaustion," "cardiac arrest," "respiratory arrest," "shock," or "uremia" without explaining the condition causing these.

66933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 741 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-1881

8. AGE: Years 67 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Joseph E. Tully

13. Birthplace Penn -

MOTHER 14. Maiden Name Rebecah H. Hamilton

15. Birthplace Md -

16 (a) Informant Mrs Mabel H. Price

(b) Address 13 Rochambeau Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore - Md

18 (a) Funeral director William Cook Inc

(b) Address 1210 St Paul St -

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept 1948, at 8.30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 18 Sept. 48.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

666934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

666934

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave.

(c) ~~Hospital~~ or institution: Edgewood Nursing Home

(d) Length of stay in ~~hospital or~~ inst. (yrs., mos., or days) 8 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Hopkins City (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lucille M. Zell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Henry S. Zell Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) about 88

8. AGE: Years: about 62 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER 12. Name: Benj. F. Mullikin

13. Birthplace: Md.

MOTHER 14. Maiden Name: Rosalena King

15 Birthplace: Md.

16 (a) Informant: Randolph C. Zell

(b) Address: 148 S. Hilton St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/21/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Loudon Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1310 St. Paul St.

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept 18 1948, and that I last saw her alive on 17 Sept. 1948.

Immediate cause of death: Coronary Occlusion — Duration: 1 hr 4 m

Due to: Arteriosclerotic-degenerative, Cardio-vascular disease — Duration: 2 Years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Jay L. Zamparo M. D.

Address: 2858 Loch Raven Blvd Date signed 18 Sept 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

666935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3431 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1869 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Regner

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife August J. Regner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1878

8. AGE: Years	Months	Days	If less than one day
70	6	2 22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Hofstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Lepsper
15. Birthplace Germany

16 (a) Informant Emma Regner
(b) Address 1869 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2330 Jefferson St.

19 (a) 20 19 [illegible] Baltimore, Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 19 48 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 47 to 9/17 19 48.
and that I last saw h alive on 9/16 19 48.

Immediate cause of death Arteriosclerotic Heart Disease
Due to Hypertensive Heart Disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E. North Date signed 9/17/48 M. D.

666936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

Registered No. 666936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1042 Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louella Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry Ruth
(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 1886 Feb

8. AGE: Years 62 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace: Fassing, Caroline Co Va (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Laurence Maynard
13. Birthplace: Caroline Co Va

MOTHER
14. Maiden Name: Lucy Hayes
15. Birthplace: Caroline Co

16 (a) Informant: Mrs. Cooper
(b) Address: 1042 Stockton St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: Sept 23 48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem
Location: Essex Co. Va

18 (a) Funeral director: James Adams
(b) Address: 1042 Stockton St

SEP 20 19[illegible] (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948, at 5-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 17 1948
and that I last saw her alive on Sept 16 1948

Immediate cause of death: Tuberculosis of the Vertebra — Duration 2 mo

Due to: Psoas Abscess

Due to: Psoas

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Edward Fisher M. D.
Address: 1612 E Monument Date signed: 9/18/48

Dr. Sawyer

66937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66937

1-21a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6028 Old Harford Road

(c) Hospital or institution:
Beach Hill Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3300 Lerch Drive
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebbel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John L. Rebbel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1863

8. AGE: Years	Months	Days	If less than one day
84	9	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Herman L. Blamberg
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. ?
15. Birthplace Germany

16 (a) Informant Mr. Wm. L. Rebbel
(b) Address 3307 Lerch Drive #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1948 to 9/17 1948, and that I last saw her alive on 9/17 1948.

Immediate cause of death Respiratory failure and Cardiac decompensation — Duration

Due to Arteriosclerotic Cardiovascular disease

Due to Nephrosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (While at work?)
(Specify type of place)

(e) Means of injury —

23. Signature James J. Weber M.D.

Address 5106 Harford Rd. Date signed 9/18/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 152

666938 Janny

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 666938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Glendale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Glendale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Georginia Meley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George Meley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58	2	13		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Deitzel
15. Birthplace Germany

16 (a) Informant Mr. George Meley
(b) Address 3101 Glendale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) SEP 20 194 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION:

20. DATE OF DEATH Sept. 17th 1948 at 1.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Sept. 17, 1948 and that I last saw h alive on Sept. 17, 1948.

Immediate cause of death Carcinoma, Pancreas — Duration 6 mos.

Due to Generalized metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1948

Major findings of operation: Carcinoma, head of pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two)
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd. Date signed 9/11/48

VS 150

G66939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66939
Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6308 North Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE T. CROWDER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 211-09-2777

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Effie V. Crowder
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1900

8. AGE:	Years	Months	Days	If less than one day
	48	1	3	hr. min.

9. Birthplace St. Georges, Island, Md.
(Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business Sparrows Point Cab Co.

FATHER
12. Name Jesse T. Crowder Sr.
13. Birthplace St. Georges Island, Md.

MOTHER
14. Maiden Name Dolly Lankford
15. Birthplace St. Georges Island, Md.

16 (a) Informant: Mrs Effie V. Crowder
(b) Address Montgomery Rd., Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1948 (month) (day) (year)
(a) Cemetery or crematory Lorraine
Location Woodlawn P.O., Md.

18 (a) Funeral director Frederick A. Wolf
(b) Address 1200 W. Lombard St.

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 19 48 at 12.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured legs. (both tibiae and fibulae)
Fractured pelvis.
Due to Fractured ribs.
Petechial hemorrhages of brain
Other Conditions Terminal bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 6.25 a. M.
(b) Where did injury occur? Old North Point Rd. in Baltimore
(c) Did injury occur at home, on farm, industrial place, or public place? public place While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed September 17, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 66940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 S. Kenwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY WILLIAM KUES

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-09-5314

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary (Arnold) Kues

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1871

8. AGE: Years 76 | Months 9 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Chauffer - retired

11. Industry or business Continental Can Co.

FATHER
12. Name Henry Kues
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. George Stevens
(b) Address 529 S. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] (Registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1948 to 9-16 1948 and that I last saw h[illegible] alive on 9-16 1948.

Immediate cause of death: Carcinoma of prostate — Duration

Due to

Due to

Other Conditions asteriorsclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Gould M. D.
Address 147 E Eastern Ave Date signed 9/20/48

666941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666941

200a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S Milton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Anna Deugwillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Felix Walter Deugwillo

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 8-15-97

8. AGE: Years	Months	Days	If less than one day
51	1	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Radomski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances
15. Birthplace Poland

16 (a) Informant Deceased
(b) Address 519 S. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 '48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director Stephen J. Falkowski
(b) Address 1918 E. Renwood Ave

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 18 1948, and that I last saw her alive on Sept 15 1948.

Immediate cause of death Hyperpyrexia

Due to Cause undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature John Rebbeye M. D.
Address St. Joseph Date signed 9-18-48

X

G66942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66942
Registered No.

4744964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correctly or as nearly correct as is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 1545 McKean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME India Granison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 3½ | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER 12. Name Lilton Wyche

13. Birthplace Va.

MOTHER 14. Maiden Name Betty Merritt

15 Birthplace Va.

16 (a) informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)

(c) Cemetery or crematory Lawrenceville

Location Virginia

18 (a) Funeral director Wagner Sanders

(b) Address 1412 E. Preston St

19 (a) (Date received by Local Registrar) 9-20-1948 Huntington Williams M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 18 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17- 1948 to 9-18- 1948. and that I last saw her alive on 9-18- 1948.

Immediate cause of death Cardiac Failure — Duration

Due to ? Syphilitic aortitis

Due to

Other Conditions ? & Bacterial endocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B Wintersnitz M.D.

Address Date signed 9-19-48

666943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAVID E. SMITH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Elizabeth Smith nee Kraft
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Nov. 12, 1869
8. AGE: Years 78 | Months 10 | Days 5 | If less than one day: hr. / min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: David E. Smith
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mr. Charles E. Smith, son
(b) Address: Silver Springs, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 20 1948 (Date rec'd by registrar) (b) Burial permit issued by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from September 15 1948 to September 17 1948 and that I last saw him alive on September 17 1948.

Immediate cause of death: Cardio Respiratory Failure — Duration: 2 days
Due to: General Hypertension and Cardio Vascular Disease — 1 year
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M. D.
Address 2015 E North Ave Date signed 9/18/48

666944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 666944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rascuk or Roscuit

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-2171

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alexandria Rascuk

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years 59 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ? Rascuk
13. Birthplace Russian

MOTHER
14. Maiden Name Not know
15. Birthplace Russian

16 (a) Informant Mrs. Anna Melnick
(b) Address 309 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Elkridge Md

18 (a) Funeral director John A. Grabiancky Jr.
(b) Address 1423 S. Paca St

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Ave., Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1948 at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 17 Sept. 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be carefully inquired correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

CORRECTED COPY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-B

✓ G66945
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. MULBERRY St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DOROTHY MAE BRYANT (BLOW)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 9, 1947.

8. AGE: Years: One | Months: 4 | Days: 5 | If less than one day: hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name WOODMAN BLOW
13. Birthplace ?

MOTHER
14. Maiden Name JAMES ANNA BRYANT
15. Birthplace NORTH CAROLINA

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N [illegible] St.

19 (a) Date received (b) Registrar

SEP 20 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 14 1948, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 9-14 1948 and that I last saw h BR alive on 9-14 1948

Immediate cause of death: Cardiac Failure — Duration:

Due to: Myocarditis of unknown etiology

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M.D.
Address Johns Hopkins H. Date signed 9-15-48

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

666946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 W. Pierce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. Pierce St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife SUSAN Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min

9. Birthplace Essex County, VA. (Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business

FATHER
12. Name George Johnson
13. Birthplace King & Queen Co. Va.

MOTHER
14. Maiden Name Rebecca
15. Birthplace ? Virginia

16 (a) Informant Robert Henry Johnson
(b) Address 1701 Pierce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 Sept 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1948. to Sept. 17 1948. and that I last saw him alive on 9-16 1948.

Immediate cause of death: Cardiac Failure — Duration: Several days

Due to Cardio-Vascular Disease — Several mos.

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 O. Franklin St. Date signed 9-18-45

VS 150

666947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Avenue
(c) Hospital or institution: Anderson Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Merrymount Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mahool

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-09-0392

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada B. Mahool

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan-24-1874

8. AGE: Years 74 | Months 7 | Days 26 | If less than one day: hr. ..... min.

9. Birthplace Phoenix, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Mahool
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Frances Hammond
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. Ada B. Mahool (wife)
(b) Address 21 Merrymount Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-21-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1.

19 (a) (b) (Signature of registrar)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Sept. 18 1948. and that I last saw him alive on Sept 18 1948

Immediate cause of death Uremia — Duration

Due to Arteriosclerosis

Due to

Other Conditions Cerebral Hemor. (May 1946)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua W. Hanson M. D.
Address 1109 St. Paul St. Date signed 9-20-48

G66948 ✓ G66948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapel Gate Lane
(c) Hospital or institution:
PINECREST SANITARIUM

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 5026 Falls St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SIMON ZALESCH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation SEXTON, SYNAGOGUE

11. Industry or business

MOTHER / FATHER
12. Name Hyman
13. Birthplace Poland
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Esther Zalesch
(b) Address No 2 E. Fallo St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Rosenberg
(b) Address 2106 Eutaw Place

SEP 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 20 1948, at 6 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948, to 9-20-1948, and that I last saw him alive on 9-19 1948.

Immediate cause of death: BRONCHO-PNEUMONIA — Duration: 20 HOURS

Due to

Due to

Other Conditions MANIC EXCITEMENT 10 WEEKS

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helmut Krager M. D.
Address 1308 Eutaw Place Date signed 9/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66949
Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME HYMAN RAINESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Beulah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs. Rainess
(b) Address 382 Pall Mall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2410 Eutaw Place

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1948 at 9 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945 to 9-19 1948 and that I last saw h[illegible] alive on 9-19 1948

Immediate cause of death Chronic nephritis

Due to

Due to

Other Conditions Chronic cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-19-48

VS 150

X

G66950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G66950
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1566 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Dinges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Frank —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-1911

8. AGE: Years 37 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Unkelbach
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Meehan
15. Birthplace Unknown

16 (a) Informant Frank Dinges
(b) Address 1566 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-41 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) SEP 10 1941 (Date received by registrar) (b)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1st Sept 1941, at 6.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty Degeneration of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. L. Ryan M.D.
Medical Examiner.
Date signed 9-8-1941

666951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N Calvert St (If rural give location)
(e) Citizen of (foreign country)? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ballantine BALLANTYNE mp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel Ballantyne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1881

8. AGE: Years 67 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Wilmington Del (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Reed

13. Birthplace Del

MOTHER 14. Maiden Name Hutchinson

15. Birthplace

16 (a) Informant Mrs Elizabeth Owens

(b) Address 924 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-45 (month) (day) (year)

(c) Cemetery or crematory Mount Salem

Location Wilmington Del

18 (a) Funeral director Chas P Powell

(b) Address 1427 Edmund Ave Balto Md

19 SEP 20 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to A.S.C.V.D. Hypertension Degenerative

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil Rayn M.D.
Medical Examiner

Date signed 19 Sept 20 45

VS 151

66952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66952 Registered No. 1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 University Pkwy. (If rural give location)
(e) Citizen of foreign country? W. Yes or No
If yes, name country

3 (a) FULL NAME Albert E. Jenifer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. sep.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. 10-15-82
8. AGE: Years 65 | Months 11 | Days 12 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER 12. Name Phillip Jenifer
13. Birthplace Md
MOTHER 14. Maiden Name Matelda Simms
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location St Mary Co Md
18 (a) Funeral director Wm J Jackson
(b) Address 916 Penna Ave
SEP 21 1948 (Date rec'd by registrar) Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948, at 2 40 M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1948 to 9/17 1948 and that I last saw him alive on 9/17 1948.

Immediate cause of death: Pulmonary infarction
Due to: due to pulmonary embolus following
Due to: operation for peptic ulcer
Other Conditions
(Include pregnancy within three months of death)
Duration: 3 weeks.

Date of operation 8/25/48
Major findings of operation: Gastric ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas N P Johns
Address Johns Hopkins Hosp Date signed 9/17

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G66953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and fully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: ST. Joseph 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E. Lanvale ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Evaline Mickens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-2-14

8. AGE: Years	Months	Days	If less than one day
33	10	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Alice Burrell
15. Birthplace Va

16 (a) Informant Diseased
(b) Address 412 E. Lanvale ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Anne Arundel Co. Md

18 (a) Funeral director Maynard A. Hemsley
(b) Address 518 W. Biddle St.

19 (Date received by Local Registrar) SEP 20 1948 (b) Burying Permit No. 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 1 25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1948 to 9-18 1948, and that I last saw her alive on 9-18 1948.

Immediate cause of death Renal Azotemia — Duration

Due to Malignant Hypertension

Due to Arteriolar Nephrosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Rutkyn M. D.
Address St. Joseph Date signed 9-18-48

VS 150

X

66954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 66954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 N. Potomac St D.O.A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 N Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. (Hartsfield) Holzhauer

3 (b) If veteran, name war: World War - I
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/1887

8. AGE: Years: 59 | Months: 1 | Days: 28 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Brewery Worker

11. Industry or business National Brewery

FATHER
12. Name Bernard Holzhauer
13. Birthplace Balto.

MOTHER
14. Maiden Name Eliz. Stock
15. Birthplace Balto.

16 (a) Informant Bernard Holzhauer
(b) Address 156 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Kelly & Zeiler
(b) Address 603 E. Lexington St, Baltimore, Md

19 SEP 20 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1948, at 5:15 M

21. I certify that I took charge of the remains described above, held an autopsy from Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to h.d death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal disease

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Pelmiscar M.D.
Medical Examiner.
Date signed 9/17/48

VS 151

MILBURN

G66955 ✓ G66955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Hanover St
(c) Hospital or institution: Provident 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702-George St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Smith Milburn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1916

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Md. Hoodsville
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stanley L. Smith
13. Birthplace Md.

MOTHER 14. Maiden Name Lillie Foote
15. Birthplace Md.

16 (a) Informant Robert Foote
(b) Address 702- George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director E. Halstead
(b) Address 918 E. Lanvale St.

19 (a) SEP 20 1948 (registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1948 at 4:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9-8 19 48 to 9-17 19 48 and that I last saw her alive on 9-17 19 48

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Bon Secours Hosp. Date signed 9-20-48

G669:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G669:56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Pylesville (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 10-18-76

8. AGE: Years 71 | Months 11 | Days 2 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and State)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Laban Lavue
13. Birthplace: Md

MOTHER
14. Maiden Name: Margaret Taylor
15. Birthplace: Md

16 (a) Informant

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 23/48 (month) (day) (year)

(c) Cemetery or crematory: Highland

Location: Street Md.

18 (a) Funeral director: Hubert P Harbin

(b) Address: Delta Pa

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

25A

20. DATE OF DEATH Sept. 20 1948, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948, to 9/20 1948, and that I last saw her alive on 9/20 1948

Immediate cause of death: Giant follicular Lymphoblastoma — Duration: 8 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John G Hull M.D.

Address Date signed Sept 20, 48

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666957

110a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Deering ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr John Wilson

3 (b) If veteran, name war None

3 (c) Social Security Account No. 214-03-5465

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ethel Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1907

8. AGE: Years 41 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and State)

10. Usual Occupation Chemical Operator

11. Industry or business Paint Chemical

FATHER 12. Name John Wilson
13. Birthplace Penna

MOTHER 14. Maiden Name Sadie Shelton
15. Birthplace Penna

16 (a) Informant Ethel May Wilson
(b) Address 2044 Deering Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George L. Schnabel
(b) Address 2101 Frederick Ave

19 (a) SEP 21 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1948 at 9:24 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/2 1948 to 9/19 1948 and that I last saw him alive on 9/19 1948

Immediate cause of death	Duration
Cardio-Resp Failure	
Due to Overwhelming Pneumonia	
Due to Mixed infection Pleural Empyema Rt	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney J. Hurst M.D.
Address St. Agnes Hosp. Date signed 9-19-48

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

66958 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County W
(c) City or town Webster Springs (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary Holcomb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6. (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-92

8. AGE: Years 56 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Samuel Dodrill
13. Birthplace W. Va.

MOTHER 14. Maiden Name Isabel Skidmore
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Wetherspring W. Virginia

18 (a) Funeral director Harry H. Wilfong
(b) Address 4104 Edmondson Ave.

19 SEP 21 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948, at 9 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1948 to 9/20 1948 and that I last saw h[illegible] alive on 9/20 1948

Immediate cause of death	Duration
GLIOBLASTOMA, RT. FRONTAL LOBE AND CORPUS CALLOSUM	6 MOS.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation SEPT. 19, 1948

Major findings of operation: GLIOBLASTOMA RT. FRONTAL LOBE

of autopsy: GLIOBLASTOMA

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Robert E. Green M D
Address Johns Hopkins Hosp. Date signed Sept 20 1948

VS 189

Please fill in, sign, and return this certificate promptly. Physicians: please write the causes of death clearly and legibly. Information should be complete and correct age is especially important.

"MEDICAL EXAMINER CASE"

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 66959

~~66959~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Monument Street
(c) Hospital or institution: Sinai Hospital of Baltimore, Inc. 15
(d) Length of stay in hospital or inst. (~~HOSPITAL~~ days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) ——

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4127 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Katz - 4127 Norfolk Avenue #16

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Newyork NY (town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER
12. Name Max
13. Birthplace Russia

MOTHER
14. Maiden Name Celia
15. Birthplace Russia

16 (a) Informant Ada Katz
(b) Address 4127 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory
Location Brooklyn N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948, at 2.15PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/4/48 19 to 9/20/48 19, and that I last saw h in alive on 9/20/48 19

Immediate cause of death	Duration
Hemotherax and Tension Pneumotherax, Right	
Due to Bronchogenic Carcinoma	
Due to right, with spread into Pulmonary vein, Esophagus and Local	
Due to Nodes.	

Other Conditions Possible Gravity Tumor, Right.
(Include pregnancy within 3 months of death)
Date of operation 9/20/48
Major findings of operation: Inoperable Carcinoma, Right Lung.
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan A. Moore M.D.
Address Sinai Hosp. Date signed 9-20-48

VS 150

Patient died just after he was removed from the Operating Table
Approved 9/20/48 - C.H. Smith M.C.

666960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 N. Brice St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Brice St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM M. GIBSON, Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1893

8. AGE: Years 55 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)
10. Usual Occupation Lead Mold
11. Industry or business National Lead Co.

FATHER
12. Name (Unknown) Gibson
13. Birthplace Va

MOTHER
14. Maiden Name Adalaide (Unknown)
15 Birthplace Va

16 (a) Informant George Gibson, Jr
(b) Address 1318 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

SEP 21 1948 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1947 to 9-20 1948, and that I last saw h[im] alive on 9-18 1948.

Immediate cause of death: Carcinoma of Pancreas — Duration: 1 Mo

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr. M.D.
Address 1227 Eutaw Blvd Date signed 9/20/48

666961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666961 Registered No. 12a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Hamilton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA E. HAMILTON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: L.H.Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.18,1861

8. AGE: Years 87 | Months 1 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard Wooten
13. Birthplace

MOTHER
14. Maiden Name Emily Muir
15 Birthplace

16 (a) Informant Charles R. Hamilton
(b) Address 1907 E. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1948 19 at 11:30 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Sept 1948 to 19 Sept 1948 and that I last saw her alive on Sept 19 1948

	Duration
Immediate cause of death: Hemorrhage Cerebral	24 hrs
Due to Arterio-sclerosis cerebral	15 yrs
Due to Hypertension Vascular	15 yrs
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C E Sisson M.D.
Address 2074 E Belvedere Ave Date signed 9/24/48

66962 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 66962

CERTIFICATE OF DEATH

1200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2048 Bank St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME ALFRED W. WOODWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Gertrude Slowikowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1923

8. AGE: Years	Months	Days	If less than one day
25	5	-	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Western Electric Co.

FATHER
12. Name Milton Woodward
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Gertrude Woodward - wife
(b) Address 2450 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/22/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore National
Location Frederick Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 SEP 21 1948 (Date filed by Registrar) **(b)** [illegible], M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1948, at 3:05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Dilation - Enlarg - Colitis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryon M.D. (Medical Examiner)
Date signed 9/20/48

VS 151

666963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pennsylvania Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE HUTCHENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47				

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lee Houchens
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Rosa Houche
(b) Address 1000 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery or crematory Louisa
Location Louisa Co Va

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

SEP 21 1948 (Date received by registrar) (b) Washington, D.C.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: [illegible] X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema due to acute congestive cardiac failure

Due to

Other Conditions Chronic alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royster M.D.
Date signed 9-20-48 Medical Examiner

111C

66964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

66964
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(b) County
(c) City or town Baltimore
(d) Street No. 3502 Powhatan Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W Perkins

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Beulah H. Perkins

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1874

8. AGE: Years: 74 | Months: 0 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Chestertown, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Eben F. Perkins
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary E. Warwick
15. Birthplace: Phila.

16 (a) Informant: Mrs. Anna Perkins Cook
(b) Address: 820 Roanoke Ave., Elizabeth, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48
(c) Cemetery or crematory
Location: Chestertown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 21 1948 (Date received by registrar) [redacted]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/48 19 at 1155A M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

22. If an external cause was present ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, or public place?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner
Date signed 9/20/48

66965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

Registered No. 66965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland St. and Baynh Ave

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2502 W. Franklin St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Franklin Higinbothom

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1884

8. AGE: Years 64 Months 3 Days 27 If less than one day hr. min.

9. Birthplace New York State (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B & O R.R.

FATHER 12. Name John B. Higinbothom

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Susan B. Harvey

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Helen D. Higinbothom

(b) Address 2502 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Edmondson & Longwood Sts.

18 (a) Funeral director John J. Curran & Son

(b) Address 901-03 W. Hollins St.

19 (a) SEP 21 1948 (Date received by Local Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948, at 3:55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 5th 1948, to Sept 20 1948, and that I last saw him alive on Sept 20 1948.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Cerebral thrombosis (a)	
Due to Hypertension arteriosclerotic cardiovascular disease	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation Sept. 16 1948

Major findings of operation: Duodenal ulcer & pancreatic adenoma

of autopsy: Autopsy obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature Katharine V. Kemp M.D.

Address West Balto Gen. Hosp. Date signed Sept. 20 1948

666966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Mem. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Beech Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Redmond

3 (b) If veteran, name war: 2

3 (c) Social Security Account No. 219-10-5059

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1925

8. AGE: Years	Months	Days	If less than one day
23	3	24	hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	John T Redmon
	13. Birthplace	Baltimore
MOTHER	14. Maiden Name	Clifton
	15. Birthplace	Talbot Co Md

16 (a) Informant: John T Redmon
(b) Address 3306 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-48

(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Frank Hoen
(b) Address 814 W 36th St

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Sept 19 48, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest
Cerebral Hemorrhage
Due to Multiple Fractures

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 19 Sept 22-48 at 3:30 A.M.
(b) Where did injury occur? Hanford Rd. 900 ft S. Harford
(c) Did injury occur at home, on farm, industrial place, or public place? Public (While at work) No
(d) Means of injury Automobile Accident

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 19 Sept 22-48

VS 151

G66967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G66967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Chesholm Road
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Chesholm Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Norah Leonard Kent

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward S. Kent
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1875

8. AGE: Years 72 | Months 8 | Days 21 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Edmond T. Leonard
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Matilda Larrimore
15. Birthplace Md.

16 (a) Informant Edward S. Kent
(b) Address 3710 Chesholm Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co., Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

7.15

20. DATE OF DEATH Sept. 18, 1948 at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1947 to Sept 18 1948.
and that I last saw h alive on Sept 18 1948.

	Duration
Immediate cause of death Ruptured Aneurysm of The Aorta	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3025 W North Ave Date signed 5/20/49

VS 150

66968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. 66968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3115 Belmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mame G. House

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: Clifford F. House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 28, 1874

8. AGE: Years 73 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick B. McManus
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Hanley
15. Birthplace Ireland

16 (a) Informant Samuel M. House
(b) Address 3115 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23 1948 (month) (day) (year)
(c) Cemetery or crematory Laurel Ridge
Location Pikesville, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) SEP 21 1948 (Date rec'd by registrar) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948 at 2 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/48 19 to 9/20 19 48, and that I last saw her alive on 9/20 19 48

Immediate cause of death: Myocardial Failure
Due to: Carcinoma of Rectum
Due to:
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation September 18, 1948
Major findings of operation: Ca of Rectum
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Faraone M.D.
Address Md. Gen. Hosp. Date signed 9/20/48

VS 150

G66969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G66969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenland Beach (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Todd
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-05-1407

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Ethel Todd
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 6/26/88

8. AGE: Years	Months	Days	If less than one day
60	2	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Edward
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Todd
(b) Address Greenland Beach, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Denny Inc.
(b) Address 760 Light St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1948 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1948 to 9/18 1948 and that I last saw him alive on 9/18 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinoma of Bladder with metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: — None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen N. Padussis M. D.
Address St. Agnes Hosp. Date signed 9/18/48

VS 150

666970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1734 Montpelier St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1734 Montpelier St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: AMELIA M. AMOS

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Walter S. Amos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1882

8. AGE: Years: 66 Months: 6 Days: 24 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER

12. Name: Frederick W. Brockman

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: Christine H. Lauterbach

15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Walter S. Amos

(b) Address: 1734 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 21 1948 (Received by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19, 1948 at 11.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 to 9-19-48; and that I last saw h alive on 9-19-48

Immediate cause of death: Myocardial insufficiency — Duration: 4 days

Due to: Cerebral hemorrhage — 9 mos +

Due to: Arteriosclerosis and hypertension — 9 mos +

Other Conditions:

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address 1517 E. North Ave Date signed 9/20/48

666971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666971

164a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BALZER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-4485

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine T. Balzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1889

8. AGE: Years 58 | Months 9 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business Baltimore American

FATHER
12. Name Bernard Balzer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Droudy
15. Birthplace Germany

16 (a) Informant: Mrs. Catherine T. Balzer
(b) Address 2716 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month, day, year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 21 1948 (Date rec'd by registrar)

19 (b) Huntington Williams, M.D.

VS 251

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948 at 9:30AM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Strangulation by hanging

Other Conditions Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary X ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-20-48 at A. M.
(b) Where did injury occur? 2715 Harlem Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging - hung self with (rafter—cellar) electric cord

23. Signature Earl L. Page M.D.
Medical Examiner.
Date signed 9-20-48

G66972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-21

Registered No. G66972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Arunah Aye. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FERDINAND M. ARNREICH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife: Augusta J. Arnreich
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	14	hr. min

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Wholesale Fish Business
11. Industry or business: Retired

FATHER
12. Name: John H. Arnreich
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louisa Rudolph
15. Birthplace: Germany

16 (a) Informant: Mrs. Louisa D. Wells
(b) Address: 2309 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 21 1948 (Date received by Registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1948 at 9:05 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1948 to Sept 18 1948 and that I last saw h[illegible] alive on Sept 2 - 48

Immediate cause of death — Duration

Due to Hypostatic Pneumonia

Due to Cardio Vascular Renal Dis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature [signature] M.D.
Address 2329 Arunah Ave Date signed 9/21/48

VS 150

G66973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66973

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the causes of death clearly and legibly.

BLANK RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Eastern ave
(c) Hospital or institution:

2-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jan Lubawski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Antonina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
about 68			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Antonina Lubawski
(b) Address 2023 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) SEP 21 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948 at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 2 1946 to SEPT. 19 1948 and that I last saw h. l. alive on SEPT 19 1948.

Immediate cause of death ARTERIO SCLEROTIC CARDIO-VASCULAR RENAL DISEASE — Duration 2/2/46

Due to

Due to

Other Conditions CHRONIC BRONCHITIS ??

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 289 [illegible] Date signed 9/20/48

VS 180

X

666974

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 666974

BC - 48-19923 CERTIFICATE OF DEATH 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital 15-12
(d) Length of stay in hospital or inst: (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Egorin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1948

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Sinai Hospital, Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Theodore Egorin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Naomi Mervis
15. Birthplace Baltimore, Md.

16 (a) Informant Mother- Mrs. Naomi Egorin
(b) Address 3722 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 21 48 (month) (day) (year)
(c) Cemetery or crematory Arabei Emunah Cem
Location Washington Blvd.

18 (a) Funeral director Sol Funeral Home
(b) Address 1124-26 W North Ave.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1948 at 9:30 am

21. I certify that death occurred on the date above stated; that I attended deceased from 19 September 1948, to 20 September 1948 and that I last saw her alive on 20 September 1948

Immediate cause of death: subarachnoid hemorrhage — Duration: 1 day

Due to birth injury

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William V. Brown, Jr. M. D.
Address Sinai Hospital Date signed 21 Sept.

VS 150

666975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 666975

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution: Bar-Wil-Ba Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Bruce Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Kellum

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0955

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Widowed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Furniture Mover

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Purdy
(b) Address 6 West Lanvale Street

19 SEP 21 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1948, at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 19 48 to 9/18 19 48, and that I last saw h[illegible] alive on 9/17 19 48.

Immediate cause of death
Cystic Pulmonary Renal Disease, Complicated by Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2 years Stage

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 608 Mulberry Street 9/21/48

VS 150

R. L. Jackson

G66976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-D

Registered No. G66976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5127 Bertram Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Kuntzman

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4239

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred Kuntzman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1904

8. AGE: Years 43 | Months 11 | Days 26 25 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Bus Mechanic

11. Industry or business Balto Transit C

FATHER

12. Name Augustus Kuntzman

13. Birthplace Md.

MOTHER

14. Maiden Name Theresa Hunt

15. Birthplace Md.

16 (a) Informant Mrs. Mildred Kuntzman

(b) Address 5927 Bertram Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director J. J. Ruck

(b) Address 5305 Harford Rd.

19 (a) SEP 21 1948 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 2 25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/48 19 to 11/20/48 19, and that I last saw him alive on 11/20/48 19

Immediate cause of death: Bronchopneumonia — Duration

Due to Cardiac decompensation

Due to Hypertension in Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William T. Hamm, M.D. M. D.

Address South Balto Gen Hosp Baltimore 30, Md. Date signed 9/20/48

G66977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66977

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 Glenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Glenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick J. Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17-1873

8. AGE: Years	Months	Days	If less than one day
74	10	3	hr. min.

9. Birthplace County Louth, Ireland (City, county, and State)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Thornton
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Morgan
15. Birthplace Ireland

16 (a) Informant Mrs. Katherine Thornton
(b) Address 709 Glenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director J. J. Luck
(b) Address 5305 Ridgewood Ave

19 (a) SEP 21 1948 (Date rec'd by Registrar) (b) Registrar's No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept. 1948 at 7.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Sept. 1948 to 20 Sept 1948. and that I last saw him alive on 20 Sept. 1948.

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration 5 yrs.
Due to
Due to
Other Conditions Cerebral Sclerosis with senile psychosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Address 5018 Sheridan Ave. Date signed 21 Sept. 48

VS 150

666978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 666978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Clipper Road.
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Clipper Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Barnes.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5908

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John H. Barnes.
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 22, 1895

8. AGE: Years 53 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Office Clerk.

11. Industry or business Cotton Duck Mill.

FATHER
12. Name Henry J. Schmid.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. LeBon.
15. Birthplace Baltimore Md.

16 (a) Informant John H. Barnes (Husband)
(b) Address 3711 Clipper Road

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-22-48. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Near Glyndon Carroll Co. Md.

18 (a) Funeral director Walter P. McNamee
(b) Address 4114 Fairfield Road

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 19 1948.
and that I last saw her alive on Sept 19 1948.

Immediate cause of death: Carcinoma Breast with metastases — Duration: 3 mo

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 371 Fallsway Date signed 9-21-48

VS 150

666979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

666979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 LIGHT ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 LIGHT ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LANG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife ANGELA E MILLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/4/1907

8. AGE: Years 41 | Months 1 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation BARBER

11. Industry or business

FATHER 12. Name JOSEPH LANG
13. Birthplace AUSTRIA

MOTHER 14. Maiden Name ELIZ. GRIESS
15. Birthplace HUNGARY

16 (a) Informant MRS JOHN LANG
(b) Address 1312 LIGHT ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director J. J. Flaherty & Sons
(b) Address 1818 Light St.

19 (Date received by Local Registrar) SEP 21 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 18 1948 at 5 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 1, 1948 to SEPT 18 1948, and that I last saw him alive on SEPT 18 1948.

	Duration
Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR DISEASE	
Due to	
Due to	
Other Conditions ARTERIOLAR NEPHROSCLEROSIS (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hourahan M.D.
Address 333 S. Ellwood Ave. Date signed 9/21/48

VS 150

927

G66980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G66980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave
(c) Hospital or institution: Home for the Aged of the Methodist Church of Balto City
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 2mo 22 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA JANE REESE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Vernon Reese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7, 1871

8. AGE: Years	Months	Days	If less than one day
77	7	12	hr. min.

9. Birthplace Near Westminster Carroll Co. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Henry Caple
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Margaret Ann Woolery
15. Birthplace Carroll Co. Md.

16 (a) Informant (Mrs. D.) Mary W. Ennis
(b) Address 2211 W. Rogers Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory WESTMINSTER
Location WESTMINSTER MD

18 (a) Funeral director Reese's Reese
(b) Address Westminster Md.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Contractor for Westminster Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to Sept 19 1948 and that I last saw her alive on Sept 18 1948

Immediate cause of death Coronary occlusion — Duration 3 days

Due to Cardio-vascular disease — ?

Due to

Other Conditions Abdominal hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Charles L. Warner M. D.
Address 424 Med. Arts Bldg. Balto 1, Md. Date signed 9/9/48

G66981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G66981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 E. 30th street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. 30th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA C. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife William J. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1859

8. AGE: Years	Months	Days	If less than one day
89	5	9	hr. min.

9. Birthplace County Clare, Ireland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Patrick Coffey
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Grace Smith
(b) Address 311 E. 30th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 11[illegible] W. Mt. Royal Ave.

19 (a) SEP 21 19[illegible] (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 19 48 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 45 to Sept 19 1948 and that I last saw her alive on Sept 17 19 48

Immediate cause of death Generalized Arteriosclerosis — Duration Indefinite

Due to —

Due to —

Other Conditions Bronco-pneumonia — Indefinite

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St. Date signed Sept. 28

VS 150

BC-48-12718

666982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 666982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balto Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Bakney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Heckmen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 4-6-48.

8. AGE: Years | Months 5 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Floyd. S Lansberry
13. Birthplace Va.

MOTHER
14. Maiden Name Anna C. Peters.
15. Birthplace Md.

16 (a) Informant family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month, day, year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McKenney
(b) Address 1302 Fort Ave.

19 (a) SEP 21 1948 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/48 19 5:06 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Kruger M.D.
Medical Examiner
Date signed 19 Sept 48

VS 151

X

G66983

AB-122594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G66983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9- 1870

8. AGE: Years	Months	Days	If less than one day
78	4	8	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1600 Bentley ave

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17- 1948 at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31- 1948, to 9-17- 1948. and that I last saw him alive on 9-17- 1948

Immediate cause of death Uremia

Due to Urinary retention

Due to Benign Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/31/48

Major findings of operation: Urinary retention

of autopsy:

Duration Days ? ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Cole M.D.

Address 4940 Eastern Ave Date signed 9/20/48

VS 150

G66984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Pine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Corbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Widower

6 (b) Name of husband or wife Mary E. Corbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1883

8. AGE: Years	Months	Days	If less than one day
65	6	14	hr. min.

9. Birthplace Caroline Co. Va., (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Corbin
FATHER 13. Birthplace Caroline Co. Va.,

MOTHER 14. Maiden Name Brady
MOTHER 15. Birthplace Caroline Co. Va.,

16 (a) Informant Sophia Corbin
(b) Address 222 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Wm. Wade R. Billings
(b) Address 322 N. Schroeder St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/18 1948, and that I last saw h[illegible] alive on 9/12 1948

Immediate cause of death Pneumonia — Duration 2 wks

Due to

Due to

Other Conditions Arteriosclerosis, Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Carmen, M.D.
Address 213 Cumberland Date signed 9/20/48

VS 150

X

G66985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N. Arlington Ave.
(c) Hospital or institution: H-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Brown. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1900.

8. AGE: Years 47 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Darlington, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Stepney Peterkin,
13. Birthplace Darlington, S.C.

MOTHER 14. Maiden Name Sarah Hamilton
15. Birthplace Darlington, S.C.

16 (a) Informant Nora Moses.
(b) Address 503 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3229 W. Schroeder St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Certificate filed at Baltimore, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/48, 19 . at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/31, 1948 to 9/19, 1948 and that I last saw h. alive on 9/19, 1948

Immediate cause of death: Cerebral Hemorrhage (Duration 1 day 1948)
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Greene M. D.
Address 622 Darlington Ave. Signed 9/20/48

666986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 666986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Harford

(c) City or town Whiteford, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 20 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Stump Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Elmer H. Bull

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) 5/20/75

8. AGE: Years	Months	Days	If less than one day
73	4	1	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name John H. Barrow

13. Birthplace Maryland

MOTHER — 14. Maiden Name Margaret Smith

15. Birthplace Maryland

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 1945 (month) (day) (year)

(c) Cemetery or crematory Deer Creek

Location Clair Md.

18 (a) Funeral director Hubert O Barkins

(b) Address Delta Pa

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 7:11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 21 1945 and that I last saw h alive on Sept 11 1945

Immediate cause of death Carcinomatosis

Due to Carcinoma of gall bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/1/45

Major findings of operation: Carcinoma of gall bladder, Cholelithiasis

If autopsy:

Duration
About 3 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify two of these)

(e) Means of injury

23. Signature John A Decker

Address Union Memorial Hosp Date signed 9/22/45 M D

VS 150

666987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 666987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Catonsville~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 0 8 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert A. Grimes

3 (b) If veteran, name war: Un
3 (c) Social Security Account No. 217-18-2652

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1914

8. AGE: Years 34 | Months 6 5 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Country Man

11. Industry or business

FATHER
12. Name F. [illegible] Oliver
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabella Lemmon
15. Birthplace Maryland

16 (a) Informant Mary L. Grimes
(b) Address 508 Hanover Ave Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 23 48 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Howard Co Md

18 (a) Funeral director H. Harry Hurt Co
(b) Address Catonsville Md

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Sept. 1948 at 8:04 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammond Jr. M.D. Medical Examiner
Date signed 21 Sept. 48

VS 101

Medical Examiner Case

666988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 N. Calhoun St.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 13 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Raspburg, Md (If outside city or town limits, write RURAL, and give town)

(d) Street No. Clayton Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Maxwell Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-9501

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Lyda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1885

8. AGE: Years	Months	Days	If less than one day
63	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Blacksmith, Retired

11. Industry or business

FATHER 12. Name Thomas Maxwell

13. Birthplace England

MOTHER 14. Maiden Name (Unknown) Morgan

15. Birthplace Baltimore, Md.

16 (a) Informant Joseph Maxwell Jr.

(b) Address Clayton Ave., Raspburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) SEP 21 1948 (Filed by registrar) (b) Huntington Maryland, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from September 20 1948 to Sept 21 1948, and that I last saw him alive on Sept 21 1948

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Jones M. D.

Address Thurmont, Md. Date signed 9/24/48

Certificate filed U. S. Vital Statistics by Thomas H. Masters, M. D.

VS 139

G66989 42-18262 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G66989

CERTIFICATE OF DEATH 119a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 E Burkehead St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA LEE BEAVERS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: unpaid
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1948

8. AGE: Years | Months | Days: 15 | If less than one day: 12 hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank M. Beavers
13. Birthplace Elkins W. Va

MOTHER
14. Maiden Name Agnes M. Floyd
15. Birthplace Balto Md

16 (a) Informant Frank M. Beavers
(b) Address 35 E Buckhead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location A. C. 20

18 (a) Funeral director C. Homer Evans
(b) Address 1400 St Paul St

SEP 21 1948 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 3 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 9-21 1948.
and that I last saw her alive on 9-21 1948.

Immediate cause of death: Uremia
Acidosis
Duration: 3 days

Due to Dehydration
Due to Toxic Nephritis
Duration: 3 days, 10 days

Due to Manilla Albumen
Duplication (Thrush)
Duration: 10 days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Revell M. D.
Address 1213 Light Street Date signed 9-21-48

VS 150

666990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lenai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Kernan (KERNAN)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Kernan (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 20, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	6	-		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Enton Garcia
13. Birthplace Spain

MOTHER
14. Maiden Name Mary Love
15. Birthplace Baltimore

16 (a) Informant John Kernan
(b) Address 2236 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Forguth Brachden
(b) Address 900 N. Eutaw St

19 SEP 21 1948 (Date rec'd by registrar) (b) Frantz & Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-48 1948 to 9-20 1948, and that I last saw her alive on 9-20 1948.

Immediate cause of death Cardiac failure

Due to Coronary Thrombosis

Due to

Other Conditions Hypertension Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 9-20-48

94a

VS 150

(666991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51

Registered No. 666991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: 1 17
Not Admitted
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days In Acc Rm
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Pine (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Levin De Shields

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C.

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 62 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business —

FATHER
12. Name Nathan De Shields
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Margaret Chase
15. Birthplace Cambridge Md.

16 (a) Informant Florence Thomas
(b) Address 30 W. Cross St.

17 (a) (Burial, cremation, or removal)
(b) Date thereof Sept 22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Jones
(b) Address 139 W. Lanvale Street

19 SEP 21 1948 (Date rec'd by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1948 to 9-19 1948 and that I last saw him alive on 9-19 1948.

Immediate cause of death cardiorespiratory failure

Due to ascites, etiology unknown, probably from metastatic cancer penis.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature John A. Rossen M. D.
Address University Hosp Date signed 9-19-48

666992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 666992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 216 N. Milton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 216 N. Milton Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. MISTER

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1876

8. AGE: Years 71 | Months 10 | Days - | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: J. Ha daway

13. Birthplace: Md

MOTHER

14. Maiden Name: Emma Haddaway

15. Birthplace: Md

16 (a) Informant: Mrs Frances Lowenthal

(b) Address: 216 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory: Tilghman Methodist

Location: Tilghman Island, Md.

18 (a) Funeral director: William Cook, Inc

(b) Address: 1217 St. Paul St.

19 (a) SEP 21 1948 (b) (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 48 to Sept 20 19 48, and that I last saw her alive on 9/19/48 19

Immediate cause of death: Carcinoma of Pancreas — Duration: 1 yr

Due to

Due to

Other Conditions: Diabetes — Long

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: H. B. Culver Lowe M.D.

Address 1901 Eutaw Place, City Date signed 9/20/48

VS 150

G66993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Fear Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Fear Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN BLAKE

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced ~~WIDOX~~ Divorced

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1872

8. AGE: Years 76 | Months 5 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Landscape Gardner Retired

11. Industry or business

FATHER
12. Name John Blake
13. Birthplace Md

MOTHER
14. Maiden Name Martha O'Donnell
15. Birthplace Md

16 (a) Informant Walter Blake
(b) Address 4015 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory St. Ignatus Hickory
Location ~~MARYLAND~~ County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) Date received by Registrar SEP 21 1948 (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1948 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Sept 15 1948, and that I last saw him alive on Sept 15 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Arteriosclerotic Heart Disease — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4415 Reisterstown Rd. Date signed 9/21/48

VS 150

G66994 A 64453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66994 Registered No. 587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Upper Marlboro (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Harmon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-24-~~26~~ 37

8. AGE: Years ~~12~~ 11 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Harmon
13. Birthplace Va.

MOTHER 14. Maiden Name Ruth Jones
15. Birthplace Penn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedarville
Location Cedarville, Md.

18 (a) Funeral director Ritchie Bros.
(b) Address Upper Marlboro, Md.

19 SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

(By information supplied by Ritchie Brothers Funeral Home, Marlboro, Md.)

MEDICAL CERTIFICATION 48 55A

20. DATE OF DEATH Sept. 21 1948, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948 to 9/21 1948, and that I last saw her alive on 9/21 1948.

Immediate cause of death — Duration

Cardiac failure

Due to acute rheumatic

Due to carditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Furey M. D.
Address Johns Hopkins Hosp Date signed 21 Sept 48

X

66995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73

Registered No. 66995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEAVE BLANK FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Aiken Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Aiken Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABBIE LOUELLA BAY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer Ross Bay

6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr): January 20, 1873

8. AGE: Years 75 | Months 8 | Days 0 | If less than one day: hr. min.

9. Birthplace: Harford County, Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Wilson Wallace
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Louisa Howlett
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mrs. Ross Bay
(b) Address: 2301 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory: Slate Ridge Cemetery
Location: Delta, Pa.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH September 20, 1948 7.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to Sept 1948.
and that I last saw h[illegible] alive on 20 Sept 1948.

Immediate cause of death: Secondary Anemia — Duration: 1 yr

Due to: Irremovable Pessary — Duration: 2 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 9/24/48

66996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 66996

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 E. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERMINDO G. BARSOTTI

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-01-6672

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha I. Barsotti
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1880

8. AGE: Years 87 | Months 11 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Giovanni Barsotti
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Cirillo
15. Birthplace Italy

16 (a) Informant Mrs Bertha I. Barsotti
(b) Address 1716 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Ave. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 19 48, at 8.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7th. 19 48 to Sept. 19th. 19 48.
and that I last saw him alive on Sept. 18th 19 48.

	Duration
Immediate cause of death: Acute Cardiac Dilitation	immediate
Due to: Myocarditis & Endocarditis	unknown
Due to: ----------	
Other Conditions: Chronic Bronchitis	unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury GEO. W. HURGATHOYD

23. Signature Geo. W. Hurgathoyd M.D.
Address 401 E. 25th. St. Date signed 9/21/48. M D

666997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 666997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 N. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 N. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES WILLARD TUCKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lottie Elizabeth

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): August 24, 1867

8. AGE: Years: 81 | Months: 0 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, state)

10. Usual Occupation: Penna. R.R.

11. Industry or business: Retired

FATHER
12. Name: John Tucker
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Perkins
15. Birthplace: Virginia

16 (a) Informant: Mrs. Lottie E. Tucker
(b) Address: 2040 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ /48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: September 20, 1948 at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Sept 20 1948 and that I last saw h[illegible] alive on Sept 18 1948.

Immediate cause of death: Carcinomatosis — Duration: Aug 1/45
Carcinoma of Stomach
Due to Pyloric Ob. ? Ca on abdominal fluid removed also
Due to
Other Conditions arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 722 N Kenwood Ave Date signed Sept

VS 150

G66998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 213 Light St

(c) Hospital or institution: So. Balto. Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4303 Nicholas Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE WEDRA

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: George Wedra

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 15, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	4	4		

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER

12. Name: Gottleib Dittman

13. Birthplace: Germany

MOTHER

14. Maiden Name: Mary Coonig

15. Birthplace: Germany

16 (a) Informant: Mr. George Wedra

(b) Address: 4303 Nicholas Avenue - 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory: Moreland Memorial Cemetery

Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC

(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at 10 50 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1948 to Sept 19 1948, and that I last saw h[illegible] alive on Sept. 19 1948.

Immediate cause of death: Gangrene right foot — Duration: 3 mos 23 days

Due to: Arteriosclerosis

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none performed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. C. Dooley, Jr. M.D.

Address 213 Light St. Date signed 9-19-48

VS 150

97

666999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

666999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3571 Fourth St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)

(d) Street No. 3571 Fourth St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William F. Conway

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sallie (Sarah) Slaughter

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1877

8. AGE: Years 71 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Railroad

FATHER

12. Name Anthony Conway

13. Birthplace Md

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Sarah Conway

(b) Address 103 E. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 22 48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick, Md

18 (a) Funeral director John F Denny Inc

(b) Address 715 Light St.

19 (a) SEP 22 1948 (Date received by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1948 at 7 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Sept 18 1948; and that I last saw him alive on 9-18-48

	Duration
Immediate cause of death Diabetes	3 mos.
Due to Cerebral Hemorrhage	
Due to Coronary Sclerosis	
Other Conditions Coronary occlusion & Hypertension	10 da

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Fred Ruzicka M.D.

Address 109 N Williams Park Date signed 9-24-48

VS 150

G67000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82R

Registered No. G67000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 151 N Poplar Grove St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 151 N Poplar Grove St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. McKEWEN

3 (b) Veteran, name war None

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife ADELINE McKEWEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 19-1884

8. AGE: Years 64 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant MARGARET J. SWEENEY

(b) Address 151 N Poplar Grove St

17 (a) BURIAL (b) Date thereof Sept 13-1948 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location Baltimore, Md

18 (a) Funeral director Jeff C. B. M. Walters

(b) Address Pratt & Stricker $18

19 SEP 22 1948 (b) Huntington Williams, M.D. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948 at 4 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 1948, to 9 - 1948, and that I last saw h-- alive on 9 - 1948

Immediate cause of death Cerebral Thrombosis — Duration 1 hr

Due to Senility & Hemiplegia — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jean Eastman M.D. M D

Address 101 Eutaw Street Date signed 9-14-48

X

667001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45c

Registered No. 667001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 882 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BURNS HATHAWAY

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 28, 1894

8. AGE: Years	Months	Days	If less than one day
54	3	22	hr. min.

9. Birthplace: Texas (Town, county, and state)
10. Usual Occupation: Oiler
11. Industry or business: Seafarer

FATHER
12. Name: John B. Hathaway
13. Birthplace: Texas

MOTHER
14. Maiden Name: Lucille Mc Queen
15 Birthplace: Texas

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Burkhart & Forman

18 (a) Funeral director: Ray B Robertson Inc
(b) Address 403 E. 25th St

19 (a) SEP 22 1948 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1948 to Sept. 19 1948, and that I last saw him alive on Sept. 19 1948.

Immediate cause of death: Carcinoma, floor of mouth with extensive metastases to liver — Duration: 12 yrs.
Due to (2) Arteriosclerosis moderate — Duration: Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director. Date signed 9/20/48

Age is especially important. Physicians: please write the causes of death clearly and legibly.

687002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. 667002

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Harford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank A. Bevans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1873

8. AGE: Years	Months	Days	If less than one day
75	1	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation gardener
11. Industry or business

FATHER
12. Name Joshua A. Bevans
13. Birthplace ?

MOTHER
14. Maiden Name Sophie D. Hederman
15 Birthplace ?

16 (a) Informant Records, Southern Home
(b) Address 2510 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Lorraine
Location Windsor Mill Road, Baltimore

18 (a) Funeral director John C. Whitehurst & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 22 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1. 1948 to Sept 21 1948, and that I last saw him alive on Sept 20. 1948.

Immediate cause of death — Duration

Due to carcinoma of stomach

Due to

Other Conditions & Cancerin + age.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home; on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M.D.
Address Medical Arts Bldg. Date signed 9-22-48

G67003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67003

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette ST.

(c) Hospital or institution: Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 201 S. Fremont Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Myrtle E. Brohawn ~~Irving L. Brohawn~~ - Myrtle E. Brohawn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Irving L. Brohawn

6 (c) If alive, give age 52 years

7. Birth date of deceased (month, day, year) June 3 - 1897

8. AGE: Years	Months	Days	If less than one day
51	8	15	— hr. — min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business At Home

FATHER

12. Name John H. Dames

13. Birthplace Baltimore - Md.

MOTHER

14. Maiden Name Gertrude E. Lantz

15. Birthplace Baltimore - Md

16 (a) Informant Irving L. Brohawn

(b) Address 201 - S. Fremont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 22 Sept. 48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Co. Md

18 (a) Funeral director C. B. Wippert Son

(b) Address 1700 Eutaw Place

19 (a) SEP 22 1948 (Date rec'd by Reg'r) (b) Huntington Woods Md

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-18 1948.

and that I last saw her alive on 9-18 1948.

Immediate cause of death	Duration
(a) Cerebro-Vascular Accident	
Due to (b) Hypertension C.V.D	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Fisher M. D.

Address Bon Secours Hosp Date signed 9-18-48

67004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 67004

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland Gen. Hosp. 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3216 Greenmount Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Howard

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wyatt G Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct 8, 1890

6. AGE: Years 57 | Months 11 | Days 13 | If less than one day: hr. min.

9. Birthplace: Boring, Md. (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER

12. Name: John H Pevergay

13. Birthplace: Baltimore County

MOTHER

14. Maiden Name: Elizabeth C. Myers

15. Birthplace: Baltimore County

16 (a) Informant: Mr. Wyatt G. Howard, husband

(b) Address: 3716 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory: Pleasant Grove Cem.

Location: Balto. Co., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) [signature illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1947 to 9/21 1948. and that I last saw her alive on 9/20 1947

Immediate cause of death: Cardiac Failure - Carcinoma of Breast with metastases — Duration: April 1945

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Frank A. Fraraino M.D.

Address: Md. Gen. Hosp. Date signed 9/21/48

VS 159

G67005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Madison Street + Tenderloin
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Grantley Street # 29 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Emma V. Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 11, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Pullman Conductor

FATHER
12. Name Adolphus J. Long
13. Birthplace N. Y.

MOTHER
14. Maiden Name Annie Cathcart
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Emma V. Long
(b) Address 730 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Tuttington-Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 6:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from September 1948, to September 2 1948, and that I last saw him alive on Sept 20 1948

Immediate cause of death Cardiac failure — Duration 6-8 mos

Due to Hypertensive Cardiovascular disease — 10 years

Due to ANASARCA

Other Conditions AURICULAR Anasarca Auricular fibrillation — 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Candler M.D.
Address Maryland General Hosp. Date signed 9/4/48

667006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town ESSEX
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 GEORGE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GUS J. STRATAKIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA STRATAKIS
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
64?			hr. min.

9. Birthplace GREECE
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JAMES STRATAKIS
13. Birthplace GREECE

MOTHER
14. Maiden Name KATHARINE GUSTOPHALIC
15. Birthplace GREECE

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lambros Inc
(b) Address 438-40 E. North ave

19 (a) SEP 22 1948 Huntington Williams, Mgr
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20 1948 at 11 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1948 to 9-20 1948, and that I last saw him alive on 9-20 1948.

Immediate cause of death circulatory collapse — Duration 4 mo. +

Due to carcinomatosis, prob. primary in pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/20/48

Major findings of operation: carcinoma liver & pancreas

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E. W. Smith M.D.
Address J.H.H. Date signed 9/20/48

G67007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G67007 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Talbarne Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Talbarne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Raimondi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Fabbruciano

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1867

8. AGE: Years 81 Months 6 Days 27 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Silvesta

13. Birthplace Italy

MOTHER 14. Maiden Name Flemma

15. Birthplace Italy

16 (a) Informant Mrs. Vincent J. Fulco

(b) Address 4024 Talbarne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location 4430 Belair Rd.

18 (a) Funeral director Harry H. Little

(b) Address 401 E. Edmondson Ave.

19 Sept 22 1948 (Date received by registrar) (By) Evelyn Wilson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1948 at 12 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 9/20 1948, and that I last saw her alive on 9/19 1948.

Immediate cause of death Bronchopneumonia (Terminal) — Duration 9/14/48

Due to Generalized Carcinomatosis — Duration 1 yr 2 mos

Due to Carcinoma of Liver — Duration 9/16/48

Other Conditions Fracture of Neck of Right Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 9/16/48 at 10 PM

(c) Where did injury occur? Balto City Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)

(e) Means of injury Fell out of Bed

23. Signature

Address 3629 Edmondson Date signed 9/21/48 M. D.

VS 150

Certified for Dr. Wm. Helfrich by Howard J. Maddis, M.D. 46F

G67008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G67008 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Aged Women's & Men's Home, 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY BLANCHE TRAUT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 24 1875

8. AGE: Years 72 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name George L. Stocksdale

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Keziah Cole

MOTHER 15. Birthplace Maryland

16 (a) Informant Union Mem. Hosp. Record

(b) Address Baltimore Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Evangelical Lutheran

Location Shrewsbury Pa.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 SEP 22 1948 (Date received by registrar) Huntington Baltimore Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24, 1948. to Sept. 21 1948. and that I last saw her alive on Sept 20 1948.

Immediate cause of death Metastatic carcinoma to lymph nodes, liver, kidney, mesentery, intestines (from primary site in sigmoid)

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-5-48 and 5-14-48

Major findings of operation: Adenocarcinoma of sigmoid colon with metastases

of autopsy: none at present

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grove M.D.

Address Union Memorial Hospital Date signed 9/24/48

VS 150

G67009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G67009 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Street and Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Overby

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2629

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Gertrude Gerard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8th 1876

8. AGE: Years	Months	Days	If less than one day
71	11	13	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Retired Supervisor

11. Industry or business Hatters Bros

FATHER 12. Name John Overby
13. Birthplace N. C.

MOTHER 14. Maiden Name Sarah Britt
15. Birthplace N. C.

16 (a) Informant Gertrude Overby
(b) Address 722 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-21 1948, and that I last saw him alive on 9-21 1948.

Immediate cause of death: Hypostatic pneumonia — Duration 11 days
Due to: Cerebro-vascular accident — 22 days
Due to: Arteriosclerotic cardio-vascular disease — 10-12 yrs
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Jones M. D.
Address Date signed

VS 150

G67010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67010 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Conkling St.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Conkling St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Piniarski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/25/92

8. AGE: Years	Months	Days	If less than one day
55	9	25	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Magnus Brown
13. Birthplace Ger.

MOTHER
14. Maiden Name Mary Wentzel
15. Birthplace Balto

16 (a) Informant Joseph Piniarski
(b) Address 125 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Leaman Hill Rd

18 (a) Funeral director Gilly & Zeluch
(b) Address 403 S. Eaton St.

19 SEP 22 1948 (Date received by registrar) (b) Huntingtn Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 48 at 12 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-20 1948
and that I last saw h alive on 9-19 1948

Immediate cause of death Coronary occlusion — Duration 1 day
Due to Coronary Thrombosis
Due to
Other Conditions
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hunsicker
Address 500 N Wolfe St Balto 9-22-48 (Date signed)

VS 190 Wh

G67011

Dr. Leutscher
12 E. Eager St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12/a

Registered No. G67011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2517 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3.(a) FULL NAME WILLIAM H. WOELPER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1876

8. AGE: Years	Months	Days	If less than one day
72	2	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Benjamin Woelper
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Germany

16 (a) Informant Mrs. Henrietta Woelper
(b) Address 2517 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Filed SEP 22 1948 (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21st 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Sept 22 1948.
and that I last saw him alive on Dec 29 1947.

Immediate cause of death: Sudden death - Acute coronary occlusion — Duration: sudden

Due to: Hypertension - myocardial insufficiency Chronic nephritis 5 yrs +

Due to: Mitral insufficiency Pulmonary oedema

Other Conditions: Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at (work)
(e) Means of injury

23. Signature John A Leutscher M.D.
Address 12 E Eager St Date signed Sept 23/48

667012 JL - 122615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

Registered No. 667012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willis Fulton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Cora
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr March 29. 1894

8. AGE: Years	Months	Days	If less than one day
54	5	19	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Contractor.
11. Industry or business

FATHER
12. Name Harry Fulton
13. Birthplace S. C.

MOTHER
14. Maiden Name Melvina ?
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Co
18 (a) Funeral director J. Mc Roth & Sons
(b) Address 1129 N. Carrollton St
19 SEP 22 1948 (Date rec'd by registrar) Huntington Williams M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 8.15 AM PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1, 1948 to Sept. 17 1948, and that I last saw him alive on Sept. 17 1948.

Immediate cause of death CARCINOMA OF PANCREAS
METASTASIS TO LIVER, PLEURA, ABDOMINAL LYMPH NODES
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration 3 Mos ?

Date of operation
Major findings of operation: None
of autopsy: SAME AS ABOVE

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Rowe P. Flanagan M. D.
Address BALTIMORE CITY HOSP Date signed 9 / 22 48

G67013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G67013 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: SINAI HOSPITAL 126
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 Berger Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Madeline Madalena HEIM Heim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John Earl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1907

8. AGE: Years	Months	Days	If less than one day
41	7	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name George H. Krauk
13. Birthplace Baltimore

MOTHER — 14. Maiden Name Minnie Oltman
15. Birthplace Baltimore

16 (a) Informant John Earl Heim
(b) Address 4319 Berger Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Mereland Memorial
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Contractor Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept. 1948 at 10 45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 15 Aug 1948 to 20 Sept 1948 and that I last saw her alive on 20 Sept 1948.

Immediate cause of death	Duration
Uremia	
Due to nephrosclerosis — pyelitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: nephrosclerosis

of autopsy: renal atrophy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Sheinis M. D.
Address Sinai Hospital Date signed 20 Sept

VS 150

G67014 ✓ G67014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Eastern Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Helen Elizabeth Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/27

8. AGE: Years	Months	Days	If less than one day
21 20	6	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis J. Bauer
13. Birthplace Balto.

MOTHER
14. Maiden Name Anita C. Madson
15. Birthplace Virgin Islands

16 (a) Informant Louis J. Bauer
(b) Address 1815 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenman Hill Rd.

18 (a) Funeral director Tully & Zeiler
(b) Address 403 S. Wolfe St

19 (a) SEP 22 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1946 to 9-19-1948 and that I last saw her alive on 9-18-1948.

Immediate cause of death	Duration
(a) Coronary Thrombosis	2 weeks
Due to (b) Streptococcus Infection	
Due to (c)	
Other Conditions Valvular heart Rheumatic Myocarditis	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature S. DeMarco M.D.

Address Medical Arts Bldg. Date signed 9-23-48

107

667015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 667015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Pardee

(c) Hospital or institution: St. Joseph 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3326 Caton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Anthony Mullen

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Della Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-97

8. AGE: Years	Months	Days	If less than one day
51 50	1	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Employee Balto Transit

11. Industry or business

FATHER

12. Name Peter B. Mullen

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Ulrich

15. Birthplace Baltimore Md.

16 (a) Informant Della Mullen (wife)

(b) Address 3326 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 23 48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location 360 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 N. Collins St.

SEP 22 1948

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948 at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 9-21 1948.

and that I last saw him alive on 9-21 1948.

Immediate cause of death Myocardial Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ASHD-Heart Generalized

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature. John M. Ballenger M.D.

Address St Joseph Date signed 9-21-48

X

G67016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95

Registered No. G67016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital ~~or other institution~~ St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1933 Gough Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Mitchell Wysocki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 27, 1914

8. AGE: Years	Months	Days	If less than one day
33	10	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Frank J. Wysocki

13. Birthplace Grabowie, Poland

MOTHER

14. Maiden Name Maryanna Andrychowska

15 Birthplace Bialowierzo, Poland

16 (a) Informant Mrs. Maryanna Wysocki

(b) Address 1933 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (a) Date rec'd by registrar SEP 22 1948

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1948 to Sept. 20, 1948, and that I last saw him alive on Sept. 20, 1948

Immediate cause of death Pulmonary Edema — Duration

Due to Rheumatic Heart Disease - Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John M Rebhuhn M.D.

Address St. Joseph Date signed 9-20-48

AI-121825
G67017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67017
Registered No. 128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Watson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Bradshaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 17- 1901

8. AGE: Years 46 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name William Bradshaw
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Faircloth
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Brooklyn Md
Location

18 (a) Funeral director Clay & Wilson
(b) Address 1800 Pentwyne

19 (a) (Date received by Registrar) SEP 22 1948 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16- 1948 at 3.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1948 to 9-16- 1948 and that I last saw him alive on 9-16- 1948.

Immediate cause of death For advanced Pulmonary Tuberculosis — Duration 2months

Due to

Due to

Other Conditions Serology of blood Positive (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M.D.
Address Balt. City Hosp. Date signed 9-20-48

X

G67018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67018
Registered No.

BC 5680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Switzer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/27/46

8. AGE: Years 1 | Months 22 | Days 8 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Carl H Switzer
13. Birthplace Virginia

MOTHER
14. Maiden Name Mallie Bryant
15. Birthplace Virginia

16 (a) Informant Mrs. Mallie J. Switzer
(b) Address 650 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md. Frederick Rd.

18 (a) Funeral director Fred. G. Cole
(b) Address 1200 W. Lombard St.

19 (a) Filed (b) rec'd by registrar Huntington Williamsport Md.

SEP 22 1948

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948 to 9-20 1948 and that I last saw him alive on 9-20 1948.

Immediate cause of death Convulsions — Duration

Due to Encephalitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Freeman M. D.
Address Univ. Hosp. Date signed 9-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 West North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 West North Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Sisselberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Stella Sisselberger
Wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	9	26		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Bank Employee
11. Industry or business

FATHER
12. Name John Henry Sisselberger
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary Quaid
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Frank Mc. Keever
Address 3012 West North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 W. North Ave.

19 (a) SEP 22 1948 (Date received by registrar) (b) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948. 10-45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Sept 21 1948.
and that I last saw h in alive on Sept 21 1948

Immediate cause of death: Duration
Due to: Chronic Wasting
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3033 W North Ave Date signed 9-23-48

VS 150

G67020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67020

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 5631 Argonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR GARDNER SMALLWOOD, JR.

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Daisy E. Smallwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1905

8. AGE Years 43 | Months 7 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Jessup, Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name Arthur G. Smallwood
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Alberta W. Hopper
15. Birthplace Howard Co., Md.

16 (a) Informant Mr. Lewis M. Smallwood
(b) Address 5000 Rittenhouse St., Riverdale Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Savage Cem.
Location Savage, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1948 (Registrar) **(b)** Registrar

STD VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 19 48 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions Chronic Alcoholism — Uremic Extinction

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner

Date signed 22 Sept 48

G67021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67021 Registered No. 129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline Street

(c) Hospital or institution: St. Joseph's Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 4640 Marbel Hall Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Edgar Vivell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/23/33

8. AGE: Years 14 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Herbert G. Vivell

FATHER 13. Birthplace Mich

MOTHER 14. Maiden Name Dorothy Jane

MOTHER 15. Birthplace Newark Del

16 (a) Informant Herbert G. Vivell

(b) Address 4640 Marbel Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Blvd

18 (a) Funeral director John C. Moran

(b) Address 3600 E Baltimore St Huntington Woods, Md.

19 (a) Date received by registrar SEP 27 1948 Registrar

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/ 1948 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16/ 1948 to 9/21/ 1948 and that I last saw him alive on 9/21/ 1948

	Duration
Immediate cause of death Cardiac Respiratory Failure	
Due to Acute Generalized Peritonitis and Mechanical Obstruction	4 days
Due to Ruptured Appendix with Appendiceal Abscess.	6 days
Other Conditions- Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation - 9/16/48

Major findings of operation:- Ruptured Appendix w abscess + Peritonitis

of autopsy: Generalized Peritonitis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Eugene L. Riley

Address St Joseph's Hospital Date signed 9/21/48

G670222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G670222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 Gay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE LANGLEY (LANGELEY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)
(c) Cemetery or crematory
Location University Medical School SEP 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature [signature] M.D.
(Medical Examiner)
Date signed 28 Aug

VS 151

G67023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G67023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belvedere & Greenspring

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1723 Thomas Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CARL METH (CARL METH.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-9429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Erna Meth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1890.

8. AGE: Years	Months	Days	If less than one day
57	9	4	hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Stock ClerK; National

11. Industry or business Casket Co.

FATHER

12. Name Moritz Meth,

13. Birthplace Austria.

MOTHER

14. Maiden Name Sophie Loewensohn,

15. Birthplace Austria.

16 (a) Informant Mrs. Erna Meth,

(b) Address 1723 Thomas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Baltimore, Md.

18 (a) Funeral director Chas. Sonnenschein & Son

(b) Address 1902 Eutaw Place Huntington Woods Baltimore, Md.

19 (a) SEP 22 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 9-22 1948 and that I last saw h[illegible] alive on 9-22 1948

Immediate cause of death — Duration

Melanosarcoma Live — 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 9-22-48

VS 150

667024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 123

667024 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3311 Colvert St
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Mt. Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Greenberry Road (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Harry ~~Meyers~~ Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	Married

6 (b) Name of husband or wife Mrs Harry Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 10 1885

8. AGE: Years	Months	Days	If less than one day
63	6	12	hr. min

9. Birthplace W. Virginia (Town, county, and state)
10. Usual Occupation Clothing Manufacturing
11. Industry or business

FATHER
12. Name J.H. Myers
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Rosenauer
15. Birthplace Maryland

16 (a) Informant Mrs. Irene H. Myers
(b) Address 2015 Greenberry Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Harris Somerington Son
(b) Address 902 Eutaw Place

19 SEP 22 1948 Date rec'd by reg. Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948, to Sept 22 1948, and that I last saw him alive on Sept 22 1948 at 6 AM

Immediate cause of death Acute Gangrene of bowel (large) — Duration 6 hours

Due to Mesenteric Thrombosis - 8 hours (Interval between onset and death)

Due to Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 22 1948

Major findings of operation: Acute Gangrene of Bowel + Mesenteric thrombosis

of autopsy: — Endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature M. F. Coyle M.D.
Address 1 Mount Royal Ave. Date signed 9-22-48

G67025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G67025
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 9540

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Bowen Court
(If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mary Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife John Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 12, 1887

8. AGE: Years	Months	Days	If less than one day
61	6	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sam Ronson
13. Birthplace West Indies

MOTHER
14. Maiden Name Margaret Carter Robinson
15. Birthplace Baltimore

16 (a) Informant Margaret Carter
(b) Address 412 Bowen Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Lawn
(b) Address 802 Mad. Ave.

19 (a) Sept 22 1948 (Date received by registrar) (b) Registrar
Transcription for Williamsburg M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Sep. 19 1948 and that I last saw her alive on Sept. 19 1948

Immediate cause of death	Duration
Cardio-respiratory collapse	
Due to Hypoglycemia	
Due to Diabetes mellitus	
Other Conditions Bilat amputations, L leg; arteriosclerosis, general	

Date of operation Sept 26, 1948
Major findings of operation: Diabetic gangrene, left foot
of autopsy? Same or other conditions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature T. Swinski, M. D.
Address Mercy Hosp. Date signed 9/19/48

X

667026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 667026

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Payson + Fayette Sts.

(c) Hospital or institution: Bon Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5 N. Catherine St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Kleophas Haiden

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Rose M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1887

8. AGE: Years	Months	Days	If less than one day
61	8	16	hr. min

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Ship Yard

FATHER 12. Name Kleophas Haiden

13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Praschinger

15 Birthplace Germany

16 (a) Informant Mrs. Rose M. Haiden

(b) Address 5 N. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan + Son

(b) Address 901-03 Hollins St.

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) [illegible] Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1948, at 2 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948, to Sept. 22 1948, and that I last saw h alive on Sept. 22 1948.

Immediate cause of death	Duration
~~Circulatory collapse~~ Pulmonary embolus	
Due to massive + generalized thrombosis	
Due to arteriosclerotic C.V.D.	

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary infarct

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature D S Mohler

Address Bon Secours Hosp. Date signed 9/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. G67027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Siani Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Henneman

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-03-0012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bill Poster

11. Industry or business Morton Outdoor Sign Co.

FATHER
12. Name Charles E. Henneman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Minnie A. Rider
15. Birthplace Baltimore, Md.

16 (a) Informant Bertha Moore
(b) Address 457 E 23rd St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1948, at 11:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/17 1948, to 9/21, 1948, and that I last saw h-m alive on 9/21 1948.

Immediate cause of death	Duration
UREMIA	
Due to ACUTE HEMORRHAGIC NEPHRITIS	
Due to PNEUMONIA,	
Other Conditions CHRONIC GLOMERULO-NEPHRITIS, CARDIAC FAILURE. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C.M. Silvestro M. D.
Address Siani Hospital Date signed 9/21/48

VS 150

C.M. Silvestro 1092

G67028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G67028

To correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 CHANCERY RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ADELE D YOST

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GEORGE YOST
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 1-29-85

8. AGE: Years 63 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name CHAS. DANKMEYER
13. Birthplace Md.

MOTHER 14. Maiden Name LENA OHLE
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Fayette St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 21 1948 at 11 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948 to 9-21 1948. and that I last saw HER alive on 9-21 1948.

Immediate cause of death: Subarachnoid hemorrhage, multiple — Duration: 3 wks.

Due to: Probable congenital aneurysm of Circle of Willis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature John B. Yost
Address
Date signed Sept 21, '48

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

667029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2435 Eutaw Place

(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Ben Paul Sandy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1903

8. AGE: Years	Months	Days	If less than one day
45	1	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Dentist

FATHER

12. Name Jacob Sandy

13. Birthplace Russia

MOTHER

14. Maiden Name Tobe Shockett

15. Birthplace Russia

16 (a) Informant Harry Freiman

(b) Address 2435 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mount Carmel Cem.

Location German Hill Road

18 (a) Funeral director Sol. Levinson & Bros.

(b) Address 1114-26 N. North Avenue

19 SEP 23 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 19 48 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1945 to Sept 14 1948 and that I last saw him alive on 9/7/48.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Samuel J. Hankin

Address 2331 Eutaw Pl. Date signed 9/22/48

VS 192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67050

67050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Frederick, Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Frederick, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GERRIT J. HOCKSTRA.

3 (b) If veteran, name war none.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Married.

6 (b) Name of husband or wife Maria G. Hockstra.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	11	17		

9. Birthplace Erk-Holland. (Town, county, and state)
10. Usual Occupation Baker.
11. Industry or business

FATHER
12. Name Tjeerd Hockstra.
13. Birthplace Holland.

MOTHER
14. Maiden Name Gast.
15. Birthplace Holland.

16 (a) Informant Mrs. Fred G. Hockstra.
(b) Address 809 Herndon Court.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept. 25/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 - Frederick, Ave.

19 (a) SEP 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1948 at 2.35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept 22 1948. and that I last saw h[illegible] alive on 22 Sept 1948

Immediate cause of death: Coronary Thrombosis — Duration 7 hrs.
Due to: Arteriosclerosis — Duration ?
Due to:
Other Conditions: Angina pectoris — Duration 4 years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Fleischer M. D.
Address 714 S. Paca St. Date signed 23 Sept 48

V S 190

X Liliensfeld

G670.31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G670.31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 N Washington St #B (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Clifford

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4167

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 2, 1887

8. AGE: Years 61 | Months 6 | Days 20. | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Sales Lady.

11. Industry or business

FATHER 12. Name John Wheeler

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Maggie Parkinson

MOTHER 15. Birthplace Md

16 (a) Informant Mrs Rachel Mowry

(b) Address 1932 N Wash St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Rd

18 (a) Funeral director Edw Tomlison

(b) Address 2359 Frank Blvd

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sept 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1948 to 9/22 1948 and that I last saw h alive on 9/22 1948.

Immediate cause of death Extensive metastatic Carcinoma of Head & Pancreas

Due to

Due to

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 9/22/48

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cannano M.D.

Address Md. Gen'l Hosp Date signed 9/22/48

VS 150

G67032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. 6670.32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2525 N. Calvert Street

(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore City

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2525 N. Calvert Street
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Sophia Hipsley

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry Lee Hipsley

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept-11-1865

8. AGE: Years 83 | Months 0 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: John Ruhl
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Zimmerman
15. Birthplace: Germany

16 (a) Informant: Mrs. W. H. Naudain (daughter)

(b) Address: 2525 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-23-1948. (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company

(b) Address: 102 N. North Avenue, City #1.

19 SEP 23 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1948, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1948 to Sept. 21 1948 and that I last saw h[illegible] alive on Sept. 21 1948.

Immediate cause of death: Bronchopneumonia — Duration 6 Days.

Due to Arteriosclerosis — Not Known

Due to Chronic Myocarditis — Not Known

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fullam R. Linton M. D.

Address 2824 St. Paul St Date signed 9/23/48

93D

G67033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G67033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Dallas (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Park Row (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myron Sigel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-33

8. AGE: Years 15 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Hyman Sigel
13. Birthplace Poland

MOTHER
14. Maiden Name Adge Berman
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Dallas Texas
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 SEP 23 1948 (Date rec'd by registrar) (b) Evrington Williams M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Sept 22 1948 and that I last saw h alive on Sept 22 1948.

Immediate cause of death: Cerebral Anaemia — Duration

Due to Congenital Heart Disease

Due to Streptococcus Sepsis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Streptococcus Sepsis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature D A Cooley M.D.
Address Johns Hopkins Hosp Date signed Sept 22, 1948

G67034 ✓ G67034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilmor Home
(c) Hospital or institution: 3520 Hilton Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Linton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Rose Schneider
(b) Address 1822 Linton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Nicholas MD Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1948 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 23 1948, and that I last saw h[illegible] alive on Sept. 22 1948.

	Duration
Immediate cause of death: Cerebral Thrombosis	7 days
Due to: Generalized Arteriosclerosis, Hypertension Cardio-Vascular	?
Due to: Diseases	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F Lerner M. D.
Address 2401 W. North Ave Date signed 9/23/48

6670.55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

✓ 6670.55 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL)
(d) Street No. 634 Sarah Anne Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eleanora Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 23, 1908

8. AGE: Years: 40 | Months: 1 | Days: 27 | If less than one day: hr. min

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business:

FATHER
12. Name: Thomas Powell, Sr.
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Cassie
15. Birthplace: Maryland

16 (a) Informant: Eleanora Powell
(b) Address: 633 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 24 1948 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location

18 (a) Funeral director: Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 SEP 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948 at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhage

Due to: Edmund Pleasants

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-19-48 at 2:15 P.M.
(b) Where did injury occur? 633 Sarah Anne Street
(c) Did injury occur at home, on farm, in industrial place, in public place? In home While at work? No
(d) Means of injury: Sharp Instrument

23. Signature: Earl L. Kay M.D.
Medical examiner

Date signed 9-20-48

V6 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1348

Registered No. 6370.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 HAMPSON ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH WALLACE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race COLORED. | 6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife SARAH ISABELLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1872

8. AGE: Years 76 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace REISTERSTOWN, MD. (Town, county, and state)
10. Usual Occupation UNEMPLOYED.
11. Industry or business

FATHER
12. Name John Wallace. 2nd.
13. Birthplace

MOTHER
14. Maiden Name Elizah Madden 2nd.
15. Birthplace

16 (a) Informant Norman Wallace.
(b) Address 5204 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Location Reisterstown, Md.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St. Huntington Indiana, Ind.

SEP 22 1948 (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948 at 7.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 5 1948 to Sept 20 1948. and that I last saw him alive on Sept 20 1948

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to TOXEMIA DUE TO URINARY EXTRAVASATION

Due to URETHRAL STRICTURE

Other Conditions VESICAL CALCULI AND DIVERTICULAE (Include pregnancy within 3 months of death)

Date of operation SEPT 5, 1948

Major findings of operation: URINARY EXTRAVASATION

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(23) Signature J. Joseph Krejci
Address 1400 N. Caroline St. Date signed 9-20-48

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66770.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66770.57

12.1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town White Hall Road
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLETTA A. BUCHANAN
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COL	MARRIED

6 (b) Name of husband or wife RICHARD
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) MARCH 31 1905

8. AGE: Years	Months	Days	If less than one day
43	5	21	hr. min

9. Birthplace HARTFORD Co MD (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Christy
13. Birthplace MD

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Richard Buchanan
(b) Address White Hall, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 1948 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Bel Air Md

18 (a) Funeral director Howard S Hamblin
(b) Address White Hall Md

SEP 23 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-48 19 , at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 9-22 1948 and that I last saw her alive on 9-22 1948.

Immediate cause of death	Duration
Resp. Fail. & cardiac failure	
Due to Hypertensive disease C-V	
Due to Renal insufficiency probable chronic nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underlie the cause from which death should be charged initially.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John White M.D.
Address University Hosp. Date signed 9-22-48

VS 150

66703.38

LH - 123018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66703.38
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 1557 Argyle Avenue
(If rural, give road and box number)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME
Rebecca Berry
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Wid.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/22/98
8. AGE: Years 50 Months Days If less than one day: hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George Davis
13. Birthplace Va.
14. Maiden Name Julia Davis ?
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept. 24, 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Ender, Md.
18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St. Baltimore, Md.
19 (a) [illegible] (b) [illegible] Registrar

Sep 28 1948
Date rec'd by Registrar

vs ss

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 48 at 7:00 AM.
21. I certify that I attended the deceased from Sept. 1, 48 to Sept. 21, 48
and that I last saw her alive on [illegible]
Immediate cause of death

Duration

Due to

Due to

Other Conditions
Resuscitation

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature M. D.
Address [illegible] Date signed [illegible]

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The certificate, with CAPITALS INK.

66703 ✓ 66703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 112a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days 70 days
(e) Length of stay in Baltimore yrs., mos., or days life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hutton Ave. & Oak Drive
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John L. Mc Laren
3 (b) If veteran, name war none
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edna G. McLaren
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 8, 1910
8. AGE: Years 38 Months 3 Days 13 If less than one day hr. min
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Administrative Office
11. Industry or business: Federal Service

FATHER
12. Name: Robert McLaren
13. Birthplace: Ureka, California

MOTHER
14. Maiden Name: Mary J. Irwin
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Edna G. McLaren
16 (b) Address: Hutton Ave. & Oak Drive, Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
18 (b) Address Balto., Md.

SEP 23 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948 10 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 2 1947 to Sept 21 1948, and that I last saw h[illegible] alive on Sept 21 1948

Immediate cause of death	Duration
(a) Coronary Occlusion	
Due to (b)	
Due to (c)	
Other Conditions	

(Enumerate progressive morbid conditions, if any, giving rise to immediate cause of death)

Date of operation 2-24-48

Major findings of operation: Gastric Ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9-21-48

VS 50

Every item of information should be carefully supplied. The CAUSE OF DEATH, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42D

667040
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5007 Ross Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME ELIZA R. WALTER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George W. Walter
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1870

8. AGE: Years: 77 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William W. Elliott
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Emma Isaacs
15. Birthplace: Ellicott City, Md.

16 (a) Informant: Mr. George W. Walter
(b) Address: 2145 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 9/24/48 (month) (day) (year)
(c) Cemetery or crematory: Trinity Cem.
Location: Long Green, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 25 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 19 48 at 8:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/ /48 19xx to 9/21/ 19 48, and that I last saw h[illegible] alive on 9/21/ 19 48

Immediate cause of death: Coma (Hypostatic Lung Congestion) — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 3703 Harford Rd. Date signed 9/24/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G67041

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 722 Hollen Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 722 Hollen Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME KATIE M. PEARCE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Parker M. Pearce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George C. Kramer

13. Birthplace Holland

MOTHER

14. Maiden Name Minnie Phiester

15. Birthplace Balto., Md.

16 (a) Informant Mr. Parker M. Pearce

(b) Address 722 Hollen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)

(c) Cemetery or crematory Fork Christian Cem.

Location Fork, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

SEP 23 1948 (Date rec'd by registrar) Bonnington Hillcrest Mort (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948 at 4:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948 to Sept 22 1948.

and that I last saw h alive on Sept 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days
Due to Arteriosclerosis cerebral	5 yrs.
Due to Hypertension	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. F. Thalson Thd M.D.

Address 620 Park Pl Date signed Sept 22 48

G67042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G67042
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. High Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EDGAR LOGAN BUNN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-7058

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Anna Bunn

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 17, 1884

8. AGE: Years 64 | Months 2 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk (retired)

11. Industry or business Balto. News

FATHER
12. Name John Snyder Bunn
13. Birthplace New Jersey

MOTHER
14. Maiden Name Eliza E. Pitt
15. Birthplace New Jersey

16 (a) Informant Mrs. Kathryn E. Bunn
(b) Address 2638 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Burington for Baltimore Md. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1948 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D. (Medical Examiner)

Date signed 9-23-48

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667043 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or Institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 N. Charles (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Dorn, Florence Louise

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-24-9756

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 16, 1917

8. AGE: Years 31 | Months 1 | Days 17 | If less than one day: hr. min. 7

9. Birthplace Casper, Wyoming (Town, county, and state)

10. Usual Occupation Administration Ass't. (U.S. Gov't)

11. Industry or business Fort Meade, Md.

FATHER 12. Name Martin Lorn
13. Birthplace Buffalo, N. Y.

MOTHER 14. Maiden Name Regina Aichele
15 Birthplace Baltimore, Md.

16 (a) Informant Miss Eva Dorn
(b) Address 2701 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Druid Hill Pk., Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 1948 to Sept. 23 1948, and that I last saw her alive on Sept. 23, 1948.

	Duration
Immediate cause of death: Toxemia with cardio-respiratory failure	36 hours
Due to: Left lower lobe pneumonia	36 hours
Due to:	
Other Conditions: Peritonitis	1 month

(Include pregnancy within 3 months of death)

Date of operation 8/16/48 9/18/48

Major findings of operation: Intra-abdominal adhesions, Pelvic abscess

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature J. Joseph Kagin M. D.
Address 1400 N. Caroline St. Date signed 9/23/48

VS 150

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 E.30th.,Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 E.30th.,Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T.Doud

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas F.Doud
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) Feb.2nd.,1885

8. AGE: Years 63 | Months 7 | Days 20 | If less than one day ########## min.

9. Birthplace Baltimore,Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Timothy J.Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Ann Dowd
15. Birthplace Ireland

16 (a) Informant Philip & Terence Doud (Sons)
(b) Address 925 E.30th.,Street

17 (a) Burial (b) Date thereof 9/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue,BaltoCo.Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] (b) Huntington Williams, M.D.
(Certified by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 19 48 to 9/22 19 48.
and that I last saw her alive on 9/20 19 48.

Immediate cause of death: Coronary Embolism — Duration: Immediate

Due to ------

Due to ------

Other Conditions Hyperacidity — about 1 month

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Murgatroyd M.D.
Address 401 E.25th. St. Date signed 9/23/48.

V S 150

667045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

667045
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3014 LINWOOD AVE~~
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 LINWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CATHERINE E. HEILL

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife HENRY PAUL HEILL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 30, 1903

8. AGE: Years 44 | Months 9 | Days 24 23 | If less than one day hr. — min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name JOSEPH KUBENIK
13. Birthplace EUROPE

MOTHER
14. Maiden Name MARY SUCHANEK
15. Birthplace EUROPE

16 (a) Informant HUSBAND
(b) Address SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 | 27 | 48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director J. Luck Stafford Co.
(b) Address 5305 Washington Blvd. Washington Heights, Md.

19 (a) (Date rec'd by registrar) 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 23 1948 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 20 1948 to SEPT 23 1948 and that I last saw HER alive on SEPT 23 1948

Immediate cause of death PULMONARY EDEMA — Duration 3 HOURS

Due to UREMIA

Due to CHRONIC NEPHRITIS

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Donald L. England M. D.
Address MARYLAND GEN HOSP Date signed 23 SEPT 48

VS 150

X

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G67046
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
USE WHITE PAPER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Woodside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Edward Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Virginia

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Dec 25-1901

8. AGE: Years 46 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Western Md dairy

11. Industry or business

FATHER
12. Name: Thomas Wilkinson
13. Birthplace: ✓

MOTHER
14. Maiden Name: Mary Virginia
15. Birthplace: ✓

16 (a) Informant: Mrs. M. V. Wilkinson
(b) Address: 3036 Woodside

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Park
Location: Balto

18 (a) Funeral director: L. J. Luck
(b) Address: 5305 Harford Rd. Huntington Wilmarco

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sept 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 9/22 1948 and that I last saw h[illegible] alive on 9/22 1948.

Immediate cause of death: Cardiac Tamponade

Duration:

Due to

Due to

Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Tamponade, Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ernest C Peramo M D
Address: Md Gen'l Hosp Date signed 9/23/48

G67047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

✓ G67047
Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1815 Alisanna St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Alisanna St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Walters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Bullock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/17/93

8. AGE: Years 55 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Oyster - Fishery

FATHER
12. Name John C. Walters
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Grimm
15 Birthplace Balto

16 (a) Informant Margaret Seitz
(b) Address 1815 Alisanna St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Easton Ave - Govd.

18 (a) Funeral director Tilly & Zeller Inc
(b) Address 403 N. Wolfe St

SEP 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 9/22/1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to Sept 22 1948 and that I last saw h[illegible] alive on Sept. 1 1948

Immediate cause of death Coronary Thrombosis — Duration acute

Due to Coronary Atherosclerosis (Fr- aug[illegible]) Arteriosclerosis — 6 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 9/24/48

VS 159

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G67048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

G67048

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3416 Virginia Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Albert Whyte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	widower

6 (b) Name of husband or wife Elizabeth S. Whyte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	29	hr. min.

9. Birthplace unknown, (Town, county, and state)

10. Usual Occupation

11. Industry or business Race Track

FATHER 12. Name John McClymont Whyte,

13. Birthplace Canada?

MOTHER 14. Maiden Name Elizabeth Ashcroft,

15. Birthplace Canada?

16 (a) Informant Mrs. Harry Graham,

(b) Address 4316 Virginia Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Sept 22 1948 at 12:3A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1948 to Sept 22 1948 and that I last saw him alive on Sept 22 1948.

Immediate cause of death	Duration
Cardio-Resp - Renal failure	
Due to Carcinoma from Carcinoma of Appendix	
Due to Uremia	
Other Conditions Fecal fistula colostomy	

(Include pregnancy within 3 months of death)

Date of operation 7/29/48; 8/12/48

Major findings of operation: Carcinoma of appendix Uremia

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert H Mackt M. D.

Address Sinai Hospital Date signed 9/24/48

Evelyn Livingston Williams Registrar

$ 5.00

Elvs 150

667049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

667049 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address So. Balt. Gen. Hosp.

(c) Hospital or institution: Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 15 min.

2. USUAL RESIDENCE OF DECEASED:

(a) State Balto. (b) County Md.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 313 E. 24th St (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Daughter of Patricia & Robert Wingon WINEGAR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 | 15 | 48

8. AGE: Years | Months | Days | If less than one day hr. 15 min.

9. Birthplace Jo. B.G.H. - Balt., Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Robert Wingon

FATHER 13. Birthplace Alabama

MOTHER 14. Maiden Name Patricia Fonahill

MOTHER 15. Birthplace Balt. Md.

16 (a) Informant Patricia Fonahill Wingon

16 (b) Address 313 E. 24th St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

17 (c) Cemetery or crematory [illegible] University Medical School SEP 22 1948

Location [illegible] Commissioner of Health

18 (a) Funeral director [illegible]

18 (b) Address [illegible]

19 (a) SEP 23 1948 [illegible] Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 | 15 | 48 (Month) (Day) (Year) at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 | 15 | 1948 to 9 | 15 | 1948, and that I last saw h[illegible] alive on 9 | 15 | 1948.

Immediate cause of death Atelectasis due to premature

Duration 15 min.

Due to Prematurity

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 9/16/48 (M.D.)

667050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182

Registered No. 667050

Type or print with PERMANENT BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier 9, Locust Point
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Portland (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Burnside St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford NEWKIRK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1889

8. AGE: Years 59 Months Days If less than one day hr min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day)

(c) Cemetery or crematory

Location University Medical School SEP 14 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 7:55AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury August at 1948 M.
(b) Where did injury occur? Harbor, Pier 9, Locust Point
(c) Did injury occur at home, on farm, industrial place or public place? Pier 9 (While at work?) ?
(d) Means of injury Drowning

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 8/19/48

VS 151

66-70:51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 66-70:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Barre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN TOWNSEND

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1917

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)

(c) Cemetery or crematory
Location University Medical School SEP 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 23 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948, at 7:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8-30-48 at 5:30 A M.
(b) Where did injury occur? Found: Howard & Camden Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public (While at work?) no
(d) Means of injury Fell to ground during epilepti

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9/3/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Medical Exam. Case -

670552 D. O. A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

670552 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL, and give town)
(d) Street No. 1511 Fairmount Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lucy Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jamaney B. Brady 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1897

8. AGE: Years 51 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lee Gavin
13. Birthplace Va.

MOTHER 14. Maiden Name Lillie
15 Birthplace Va.

16 (a) Informant.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Goochland Co. Va.

18 (a) Funeral director Mrs. Robert A. Ellison Dept.
(b) Address 1129 N. Carolina St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

vs 150 To be appro. by the Med. Examiner

MEDICAL CERTIFICATION

50

20. DATE OF DEATH Sept 20 1948 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20-1948 to 9-20-1948 and that I last saw h[illegible] alive on 9-20-1948.

Immediate cause of death: Lobar pneumonia — Duration: days.

Due to bacterial infection — days.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia, Rt.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Anthony J. Zito M.D.
Address Johns Hopkins Hosp. Date signed 9-21-48

Certification approved by Carl H. Davis

For John R. Davis, M.D

Physicians are especially important. Physicians: please write the causes of death clearly and legibly.

BC-48-20125

667053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667053

159a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Duncan (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Szymski, Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1948

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Adam James Szymski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hilda Mary Szymski
15. Birthplace Baltimore, Md.

16 (a) Informant Adam J. Szymski
(b) Address 404 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Clark Bros & Sons
(b) Address 900 N. Charles St

19 (a) SEP 23 1948 (Date received by registrar) Contington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948 at 4:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19, 1948 to Sept. 23, 1948 and that I last saw her alive on Sept. 23, 1948

Immediate cause of death	Duration
Medullary Herniation	
Due to Spina bifida Hydrocephalus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury

23. Signature John Rellaye M. D.
Address St. Joseph Date signed 9-23-48

VS 139

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Any error or information should be carefully supplied. The

G67054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 W. 41st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 W. 41st Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie C. Longenecker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Solomon Longenecker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 15, 1864

8. AGE: Years 84 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Graceham, Frederick Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George D. Hoover
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Shearer
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Grace Rairigh
(b) Address 1332 W. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminister, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b)
(Signature and address of registrar) (Registrar)
SEP 23 1948 Lillington Williams M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 22, 1948 at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 9/22 1948. and that I last saw h[illegible] alive on 9/21 1948.

Immediate cause of death: Arteriosclerotic heart — Duration: yrs

Due to Arteriosclerosis — yrs

Due to cerebral thrombosis — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.

Address 2020 N. Charles Date signed 9/23/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

667055

Sr. 5406

667055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1212

Registered No. 667055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Angela Sell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Sell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1917

8. AGE: Years 31 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Maryland, Carroll Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Doyle
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie McCaffrey
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address Emergency.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept 25 48 (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Westminster Carroll Co.

18 (a) Funeral director P Burkard & Son
(b) Address Westminster Md.

19 SEP 24 1948 (Date rec'd by registrar) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/48 19 to 9/23 19, and that I last saw her alive on 9/23 1948.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Chronic glomerular nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Siwinski

Address Mercy Hosp Date signed 9/24/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

667056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

667056
Registered No.

Type or print in ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Same St (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 H Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James J. O'Toole

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-80

8. AGE: Years 68 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William O'Toole
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Moran
15. Birthplace Ireland

16 (a) Informant Same
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 25 1948 (month) (day) (year)
(c) Cemetery or crematory RIVERVIEW CEMETERY
Location WILMINGTON DELAWARE

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 WINDSOR AVE.

19 SEP 24 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-1948, at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-1948, to 9-23 1948, and that I last saw h/m alive on 9-22 1948.

Immediate cause of death: Carcinoma of Liver
Contributory Conditions

Duration

Due to

Due to

Other Conditions

(Interval between onset and death) months (if death)

Date of operation 9-21-48

Major findings of operation: Same as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William O'Toole M. D.
Address Same Date signed 9-23

VS 150

667057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667057

BS-115594

47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie M. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1887

8. AGE: Years 61 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Frederick Wissussek
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant RECORDS. Balto City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory ST. PAUL'S FIFTH REFORMED CHURCH
Location BALTO. MD.

18 (a) Funeral director Roland L. Fuller
(b) Address 2112 DUNDALK AVE.

19 (a) SEP 24 1948 (Date received by local registrar) (b) Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1948 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1947 to 9-21 1948, and that I last saw h er alive on 9-21- 1948.

Immediate cause of death: Bronchogenic carcinoma — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kerlavage M. D.
Address Balto City Hosp. Date signed 9-22-48.

VS 150

Please answer all questions. Information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G667058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G667058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 WYETH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 WYETH ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

5 (a) FULL NAME LYDIA BREITENBACH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LOUIS BREITENBACH
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) MARCH 20 1887

8. AGE: Years 61 | Months 6 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name NOT KNOWN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant LOUIS BREITENBACH.
(b) Address 609 WYETH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-27-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM
Location FREDERICK ROAD

18 (a) Funeral director BERNARD C. HARLEY
(b) Address 121 E WEST ST

19 (a) SEP 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 23 1948, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1948 to 9-23 1948 and that I last saw h[illegible] alive on 9-23 1948.

	Duration
Immediate cause of death Coronary Thrombosis	Sudden
Due to Coronary Artery Disease	6 week
Due to	
Other Conditions Cholelithiasis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Upfold Jr.
Address 1222 Wash Blvd Date signed 9-24-48

VS 150

667059

JL - 123018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 667059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 1 1900

8. AGE: Years 48 | Months ? | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Holland
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof Sept 24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James Astarjos
(b) Address 1422 W. Pratt St.

19 SEP 24 1948 Huntington Williams Mgr.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1948 at 5.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1948 to Sept. 21 1948. and that I last saw him alive on Sept. 21 1948.

Immediate cause of death CARDIAC FAILURE — Duration 1 MO

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE — ?

Due to CONGESTION OF LUNGS, LIVER, & KIDNEYS

Other Conditions UREMIA
(Include pregnancy within 3 months of death)

Date of operation N

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address BALTIMORE CITY HOSP. Date signed 9-22-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

G67060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67060 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Type

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 W. Montgomery
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 W Montgomery
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benton Wickes
13. Birthplace Md

MOTHER 14. Maiden Name Francis —
15. Birthplace

16 (a) Informant Chauncey Smith
(b) Address 632 Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stevens
(b) Address 1142 W. Pratt St

19 (a) SEP 24 1948 (Date rec'd by reg.) Huntington Williams Type

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 19 48 to Sept 20 19 48 and that I last saw h alive on Sept 20 19 48

Immediate cause of death: Cardio Vascular Renal

Duration
1

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Washington M. D.
Address 5 W Chesapeake Date signed 9-21-48

VS 150

Q67061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 6620

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 S Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert E. Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1890.

8. AGE: Years 58. | Months | Days | If less than one day hr. min.

9. Birthplace Annandale Co My (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name George Snowden
13. Birthplace a a Co.

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Robert E. Lee
(b) Address 1021 S. Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James Astarjos
(b) Address 142 W. Hill St

19 (a) SEP 24 1948 (Date rec'd by registrar) Huntington, W. Virginia, M.F.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948, to Sept 21 1948, and that I last saw her alive on Sept 20 1948.

Immediate cause of death Cerebral Thrombosis
Myocarditis

Due to Hypertension
Pregnancy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Snowden M. D.
Address 142 W See St Date signed 9/23/48

VS 150

667062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. 667062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. F. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-09-0258

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Amelia E. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1880

8. AGE: Years 68 | Months 5 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Collector
11. Industry or business retired

FATHER
12. Name Henry Miller
13. Birthplace Baltimore

MOTHER
14. Maiden Name Agnes C. Eichel
15. Birthplace Baltimore

16 (a) Informant Mrs. Amelia E. Miller
(b) Address 2307 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 SEP 24 1948 (Date received by registrar) (c) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1947 to Sept. 22 1948 and that I last saw him alive on Sept 22 1948.

Immediate cause of death Carcinoma of Prostate — Duration 3 yrs?
Due to
Due to
Other Conditions Myocardial Degeneration (Include pregnancy within 3 months of death)
Date of operation Sept. 16, 1946
Major findings of operation: Carcinoma of Prostate
of Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Duncan B. Baker M. D.
Address 845 N. Patterson Park Ave signed 9/23/48 M. D.

16703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 16703

Lot 121061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schafline (Schaflein)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M

5. Color or race W

6 (d) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Florence Schaflein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1879

8. AGE: Years 79 Months 8 Days 6 If less than one day hr. min. 69

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name (illegible) Peter Schaflein

13. Birthplace Germany

MOTHER 14. Maiden Name Tillie ? Herman

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals

(b) Address 4941 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24/48 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto. Md.

18 (a) Funeral director Philip Sherry Sons

(b) Address 2024 Orleans St.

19 SEP 24 1948 (Date rec'd by registrar) (b) Clayton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 21- 1948, at 1:15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-7- 1948 to 9/21 1948 and that I last saw h[illegible] alive on 1948

Immediate cause of death: Toxemia

Due to: Infected amputation stump

Due to: Arteriosclerosis Gangrene Left Extremities Lower

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/23/48

Major findings of operation: Gangrene right leg

of autopsy:

Duration: age 2 mos. Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Poe M.D. M. D.

Address 4941 Eastern Ave Date signed 9/24/48

VS 150

X.

G67064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G67064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Copley Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Copley Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCIE G. GERE.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henri Gere.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1876.

8. AGE: Years 71 | Months 11 | Days 26 | If less than one day: hr. min.

9. Birthplace Paris, France. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Charles Gilbert,
13. Birthplace France.

MOTHER 14. Maiden Name Unknown,
15. Birthplace France.

16 (a) Informant Mrs. Sampson Pike,
(b) Address 3506 Copley Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director [illegible] Sons
(b) Address 1902 Eutaw Place.

19 (a) SEP 24 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Last 1945, and that I last saw her alive on July 30 1945.

Immediate cause of death Cerebral Thrombosis
Due to Arteriosclerosis
and hypertension
Due to
Other Conditions

Duration 9/22/48

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold W. Hoon M. D.
Address 5721 Pk. Heights Ave. Date signed

VS 150

X

CORRECTIONS, IF ANY, MUST BE MADE BY REGISTRAR AND WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town (If outside city or town limits, write RAL and give town)
(d) Street No. 1001 Woodyear Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1902

8. AGE: Years 46 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Dendron, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eddie Hite
13. Birthplace Va.

MOTHER
14. Maiden Name Malinda Young
15. Birthplace Va.

16 (a) Informant Alice Brown
(b) Address 1416 Shipp St. Norfolk, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month)
(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director Charles R. Law
(b) Address 302 Madison Ave.

19 SEP 24 1948 (Date rec'd by registrar) Livingston Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1948 at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What kind of place?
(d) Means of injury

23. Signature Howard J. Maldeis M.D. Medical Examiner.
Date signed 9-23-48

(Under age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667066

667066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 - Linwood Hill ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 - Linwood Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hawkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr) 7-5-1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Laura Lipscomb
(b) Address 932 - Linwood Hill ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halsted
(b) Address 945 - Linwood Hill ave.

19 SEP 24 1948 (b) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1948, at 12 05 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9 18 1948 to 9/22 1948. and that I last saw him alive on 9/20 1948.

Immediate cause of death Chronic Cardiovascular renal disease d/t hypertension — Duration 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged; statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Jackson M.D.
Address 930 N. Eutaw St. Date signed 9/24/48

VS 150

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

6670n7 48-10799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104a

Registered No. 6670n7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES PICKETT

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ——

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1948

8. AGE: Years | Months 4 | Days | If less than one day ... hr. ... min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed (infant)

11. Industry or business

FATHER
12. Name ? Pickett
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Garris
15. Birthplace Unknown

16 (a) Informant Mary Garris
(b) Address 1506 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 24 1948 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948 at 10:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy/ Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryan M.D.
Medical Examiner
Date signed

VS 151

Physicians: please write the causes of death clearly and legibly.

667068

667068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

Registered No. 667068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution: Maryland Baptist Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Silas C. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1870

8. AGE: Years 77 | Months 11 | Days 22 | If less than one day: hr. min.

9. Birthplace Westmoreland (Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

MOTHER / FATHER

12. Name Silas Carter

13. Birthplace Virginia

14. Maiden Name Lucy Thompson

15. Birthplace Virginia

16 (a) Informant Mrs. Daniel Ringgold

(b) Address 925 Hartley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) SEP 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/48 19.. at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19/48 to 9/21/48, and that I last saw him alive on 9/21/48

Immediate cause of death: Acute Myocarditis

Due to: Acute Arthritis

Due to: Pneumonia

Other Conditions: Congestive Bronchitis (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Barksdale M. D.

Address 526 N. Carey St. Date signed 9/24/48

Duration: Chronic

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

67069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 67069

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Mott Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Mott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Bush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie Bush

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 19, 1894

8. AGE: Years 54 | Months 4 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Baltimore Ct. House

11. Industry or business Library

FATHER
12. Name William F. Bush
13. Birthplace Easton Shore Maryland

MOTHER
14. Maiden Name Martha
15. Birthplace Maryland

16 (a) Informant Mrs Elsie Bush
(b) Address 1121 McDonough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 1948 (month) (day) (year)
(c) Cemetery or crematory Western Run
Location Baltimore County Md

18 (a) Funeral director Joseph A Lucy
(b) Address 64 West Saratoga Street

19 SEP 24 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1948 to 9-22-1948 and that I last saw him alive on 9-22 1948.

Immediate cause of death
Pulmonary Tuberculosis
Due to Bronchio Pneumonia

Duration 60 days

Due to Bronchio Pneumonia 10 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Blake Caroline M. D.

Address 1603-N Date signed 9-24-48

VS 150

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

67070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G67070 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Kolb ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Edw. B. Lutz
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) 1-9-1888

8. AGE: Years	Months	Days	If less than one day
66	9	11	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Hochhausen
13. Birthplace Balto.

MOTHER
14. Maiden Name Frances Strobel
15 Birthplace Balto

16 (a) Informant Edw B Lutz Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Dippel Bros.
(b) Address 7110 Belair Rd.

19 SEP 24 1948 (Date rec'd by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948, at 7.29 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948 to 9-22 1948, and that I last saw h[illegible] alive on 9-22 1948

Immediate cause of death Acute pulmonary edema — Duration 2 hrs.

Due to Myocardial infarction

Due to Coronary thrombosis

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ann Powell Jr M. D.
Address Mercy Hosp Date signed 9-23-48

VS 150

94a

67071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

(Registered No.) 67071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 668 W. Fairmount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME CHARLES VINCENT emw

3 (b) If veteran, name war No

3 (c) Social Security Account No. 213-10-2429

4. Sex M | 5. Color or race C | 6 (d) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alverta Vincent

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9/30/1908

8. AGE: Years 39 | Months 11 | Days 23 | If less than one day 12 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Grace
15. Birthplace Maryland

16 (a) Informant Alverta Vincent
(b) Address 687 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md

18 (a) Funeral director Charles Herbert
(b) Address 512 Carrollton Ave

19 (a) SEP 24 1948 (Date rec'd by registrar) Wellington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948, at 7:55 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to strangulation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 22, 48 between 3 A.M. & 6:30 A.M.
(b) Where did injury occur? 668 W. Fairmount St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury hung self with belt

23. Signature Emil R. Rogan M.D.
Medical Examiner

Date signed 9/22/48

×

Dr. Hayward 667072 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667072
13 E. Eager CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthias Leimkuhler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 27, 1864

8. AGE: Years	Months	Days	If less than one day
83	11	2827	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary, Bldg. Asso.

11. Industry or business

FATHER
12. Name John M. Leimkuhler
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Barbara Knapp
15. Birthplace Bedan, Germany

16 (a) Informant Miss Mary Leimkuhler
(b) Address 3501 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road "14

19 SEP 24 1948 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30, 1947 to Sept 24 1948, and that I last saw him alive on Sept 23 1948.

Immediate cause of death: Acute Myocardial Collapse — Duration: 4 hours
Due to Coronary Thrombosis — Duration: 18 hrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Hayward
Address 13 E Eager St Date signed 9/24/48

VS 150

667073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667073 Registered No.

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6700 Youngstown Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wasil PANASUK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-5196

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Panasuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russian
(Town, county, and state)

10. Usual Occupation: Steel Work

11. Industry or business: Bethlehem Steel

FATHER
12. Name: ? Panasuk
13. Birthplace: Russian

MOTHER
14. Maiden Name: Not Know
15. Birthplace: Russian

16 (a) Informant: Mrs. Anna Panasuk
(b) Address: 6700 Youngstown Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Trinity Russian
Location: Elkridge, Md.

18 (a) Funeral director: John A. Grabliauckas
(b) Address: 425 S. PACA St.

19 (a) SFD 9 1948 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 48, at 9:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to

Other Conditions fracture R. femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-48 at 6:45 P M.
(b) Where did injury occur? Bethlehem-Sparrows Pt.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Slipped and fell to floor

23. Signature Emil K. Konzo M.D.
Medical Examiner
Date signed 23 Sept 48

667074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

667074 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** FRANK MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) [illegible]

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Henry Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Annie Miles
(b) Address 1317 Madison Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

SEP 24 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948 at 3A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Sept 21 1948, and that I last saw h alive on 9/20 1948.

Immediate cause of death	Duration
Chronic Cardio vascular renal disease	1 yr. Mos.
Due to Cerebral Thrombosis	Mos.
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Carson M. D.
Address 627 N. Eutaw Date signed Sept 24 1948

K. L. Carlson

667075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667075 Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs.) Mary Frances Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1890

8. AGE:	Years	Months	Days	If less than one day
	58	6	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Phillip Cooper
13. Birthplace Md.

MOTHER 14. Maiden Name Rosie Spencer
15. Birthplace Md.

16 (a) Informant Mrs. Susie Jackson
(b) Address 709 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) 1948 (b) Clayton Williams, M.D. Registrar
(Date rec'd by registrar)

L2

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Sept. 1948 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Metastasis from Carcinoma of Breast

Due to

Other Conditions Chronic Myelogenous Leukemia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammond - M.D. Medical Examiner
Date signed 23 Sept. 48

Please write the causes of death clearly and legibly. The ... should be carefully supplied. This ... very important. Physicians: ...

BC-C09816 667076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 667076 Registered No. 520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life..

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Dulaney Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Ronald Wm Clevenger II RONALD WAYNE CLEVINGER II

3 (b) If veteran, name war ********** 3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife SINGLE 6 (c) If alive, give age S. years

7. Birth date of deceased (mo., day, yr.) Sept. 28 1944

8. AGE: Years	Months	Days	If less than one day
3	11	25 24	***hr. ********min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None.... Child
11. Industry or business

FATHER	12. Name	JACOB F. CLEVINGER
	13. Birthplace	PA.
MOTHER	14. Maiden Name	GRACE M. BAILEY
	15. Birthplace	MARYLAND

16 (a) Informant: JACOB F. CLEVINGER (father)
(b) Address 2641 Dulaney Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 GUILFORD PLACE...17
Huntington Williams, M.D.

19 (a) Date received by registrar SEP 24 1948 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-22 1948, and that I last saw him alive on 9-22 1948.

Immediate cause of death metastatic malignancies — Duration

Due to Wilm's tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Bruns M.D.
Address Univ Hosp Date signed 9-22-48

H. J. Bell, Jr.

VS 150

Please answer all questions as especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Lab - 122967 667077 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Bethelhem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Batching
3 (b) If veteran, name war
3 (c) Social Security Account No. 312-09-5253

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 7. 1900
8. AGE: Years 47 | Months 10 | Days 14 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Seamen. American Can Co.
11. Industry or business

MOTHER / FATHER
12. Name Henry Batching
13. Birthplace Md.
14. Maiden Name Anna Broken (Bratley)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25. 1948 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Irages Road.

18 (a) Funeral director J. WENDELL J. DIPPEL
(b) Address 312 S. Highland Ave.

19 (a) SEP 24 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 21- 1948 at 1:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Myocardial infarction? — Duration 1 min

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature H. T. Nelson M. D.
Address BCH Date signed 9-22-48

Huntington Williams, M.D.

VS (B)

Please write plainly. Physicians: please write the causes of death clearly and legibly.

Asl 667078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667078
Registered No.

8.2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince
(c) City or town Capitol Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John Horton

3 (b) If veteran, name war (-)

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-22

8. AGE: Years	Months	Days	If less than one day
25	26	11	21 hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Bus Driver

11. Industry or business

FATHER 12. Name John Horton
13. Birthplace Va

MOTHER 14. Maiden Name Charlie Bosley
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Sept 24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bonsley Cem
Location Hillsville Va

18 (a) Funeral director Ellyn Funeral Home
(b) Address 2008 Orleans St

SEP 24 1948 (b) Huntington Md
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-24 1948, and that I last saw him alive on 9-24 1948

Immediate cause of death Bulbar paralysis, acute — Duration 2 days

Due to Myasthenia Gravis — 3 years

(MYASTHENIA GRAVIS)

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Latham E. Sprague
Address Johns Hopkins Hospital Date signed 9-24-48

VS 150

CERTIFICATION APPROVED BY G67079

Hiram Winternitz M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G67079
Registered No.

1. PLACE OF DEATH (MEDICAL CERTIFICATE)
(a) Baltimore City, Maryland
(b) Street address Calow & Wilkins Ave
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Summit Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Donnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/13/1850

8. AGE: Years 85 | Months 1 | Days 10 | If less than one day hr. min. 1860

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Bryan O'Donnell

13. Birthplace Ire. U.S.A.

MOTHER 14. Maiden name Anne Marie Cusick

15. Birthplace

16 (a) Informant Edgar O'Donnell

(b) Address 1813 Summit Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 27-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore City

18 (a) Funeral director John R. Young

(b) Address 1st Aletheimer md

19 (a) 9/27/46 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/ 19 46 (month) (day) (year) 8:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/30 19 46 to 9/23 19 46, and that I last saw him alive on 9/23 19 46.

Immediate cause of death: Cardiac Failure

Duration 2 1/2 yr

Due to Acute Gastritis

Due to Fecal Impaction of Left Colon

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Fall - slipped & fell to floor (inside)

23. Signature (Coroner)

Address Date signed 9/23/46

VS 150

667080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2143 W. Baltimore St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Paul George Dittrich

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma A. Dittrich
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.) August 20, 1895

8. AGE: Years 53 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county and State)
10. Usual Occupation: Butcher
11. Industry or business: self

FATHER
12. Name: Edward M. Dittrich
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Brettschneider
15. Birthplace: Germany

16 (a) Informant: Mrs. Emma A. Dittrich
(b) Address: 2143 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave.

19 (a) [illegible] (b) [illegible] Registrar
Huntington Williams, M.D.

SEP 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to 9/24 1948 and that I last saw him alive on 9/23 1948

Immediate cause of death

Coronary Thrombosis — Duration: 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. A. Carter, M.D.
Address 2145 W. Balto St. Date signed 9/24/48

X

667081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

667081 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Aisquith St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME IDA L. TALBOTT

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James E.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Dec. 27, 1869

8. AGE: Years: 78 | Months: 8 | Days: 24 27 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Miller
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Frances Miller
15. Birthplace: Baltimore County, Md.

16 (a) Informant: James Talbott
(b) Address: 2219 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/48 (month) (day) (year)
(c) Cemetery or crematory: Protestant Methodist
Location: New Market, Baltimore Co., Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948, at 5:53 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 - 1946 to 9-23 - 1948, and that I last saw her alive on 9-18 - 1948

Immediate cause of death Organic Heart Disease — Duration unknown

Due to

Due to

Other Conditions Diabetis — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Chester Kilmon

Address 253 E Edmondson Ave Date signed 9-24-48

VS 150

9 E c

667082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 667082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Old Spring Ave
(c) ~~Hospital or~~ institution: " " Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Robert J. Lytle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Grace E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1866

8. AGE: Years	Months	Days	If less than one day
82	3	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name (Unknown) Lytle
FATHER 13. Birthplace "
MOTHER 14. Maiden Name Sarah V. Cassell
MOTHER 15 Birthplace "

16 (a) Informant Robert B. Lytle
(b) Address 23 E. Susquehanna Ave Tow

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23rd 1948, at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1948 to 9-23 1948 and that I last saw h~~im~~ alive on 9-23 1948.

Immediate cause of death: Generalized Arteriosclerosis. — Duration: 15 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kennian
Address 3803 Edmondson Ave Date signed 9/24/48 (M) (D)

VS 150

667083 CERTIFICATE CORRECTED 9-1-50 ✓ 667083

JL - 118905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. Lorraine Ave.-18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos S. Stewart or S. Amos Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 16, 1871

8. AGE: Years	Months	Days	If less than one day
77	6	6	hr. min.

9. Birthplace Md. (Maryland (S.))
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Stewart
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Herrman
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)

(c) Cemetery or crematory Dulaney
Location

18 (a) Funeral director Wilson Roth, Inc
(b) Address 217 E. Read St.

19 (a) SEP 25 1948 (b) Washington Blvd.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Sept. 22 1948 at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to Sept. 22 1948.
and that I last saw him alive on Sept. 22 1948.

Immediate cause of death CVA — Duration mins.

Due to Hemorrhage Cerebellum — Duration yrs

Due to — Duration

Other Conditions Sclerosis Arteriosclerosis — Duration yrs
(Include pregnancy within 3 months of death)

Date of operation None performed

Major findings of operation: None performed

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Erith M. D.
Address Balt. City Hosp. Date signed 9/23/48

VS 150

667084 4P-19826 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667084

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County .....
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 ST. JAMES ST
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME BABY "LILLIE MAE" HOLT

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex FEMALE | **5. Color or race** COLORED | **6 (a)** Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 9-17-48

8. AGE: Years — | Months — | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20 1948, at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-20 1948, and that I last saw HER alive on 9-20 1948.

Immediate cause of death ..... **Duration** .....

Due to Prematurity

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury .....

23. Signature A. C. Fang M. D.
Address Johns Hopkins Hosp Date signed 21 Sept 48

VS 150

Physicians: please write the causes of death clearly and legibly. The information requested is important.

BC-48-20239 ✓ G67085

G67085

JL - 122882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G67085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Boone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hinton- Romaine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1948

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Andrews
13. Birthplace Ga.

MOTHER
14. Maiden Name Romaine Harris
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-13-48 9am (month) (day) (year)
(c) Cemetery or crematory B.C.H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington-Williams Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948, at 12.30 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Sept. 11 1948, to Sept. 12 1948, and that I last saw him alive on Sept. 12 1948.

Immediate cause of death: Congenital Heart abnormalities — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Heart + atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W M Cox M. D.

Address 4940 Eastern Ave Date signed 9/15/48

VS :50

G67086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Doctors Hospital Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gibbons, Myrtle — Myrtle F. Gibbons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	25 2/6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul L. Lind
13. Birthplace Md.

MOTHER
14. Maiden Name Lula Witz
15. Birthplace Md.

16 (a) Informant Paul C. Linde
(b) Address 3026 Harlen Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Little
(b) Address 4101 E. Edmondson Ave.

19 (a) SEP 25 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Sept 24 1948, and that I last saw her alive on Sept 3 1948.

Immediate cause of death: Cerebral Accident
Due to Hypertensive Cardio Vascular Disease
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1941

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury
23. Signature W. O. Keadle
Address 314-00 Wash. Blvd. Date signed 9/24/48.

VS 150

Physicians: please write the causes of death clearly and legibly. Every question should be carefully answered. It is very important.

667087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 667087

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 Lyndhurst St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Lyndhurst St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion P. Rippel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Conrad D. Rippel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name George Foster
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Courtney
15. Birthplace England

16 (a) Informant Mr. Conrad D. Rippel
(b) Address 306 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext. Balto. Md.

18 (a) Funeral director Harry A. Luetke
(b) Address 4101 Edmondson Ave.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Lexington Millause, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23/48. 19 , at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept 23 1948, and that I last saw her alive on 23 Sept 1948.

Immediate cause of death Metastasis from Carcinoma of left Breast — Duration 4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. H. Thompson M. D.
Address 2058 Garland Ave. Date signed 27 Sept 48

VS 150

667088

667088

BC- F 81748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

Registered No. 667088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 White ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Forrester Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 7, 1943

8. AGE: Years	Months	Days	If less than one day: hr.	min.
5	1	17		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gilbert C. Forrester Sr
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte G. Rankin
15. Birthplace Maryland

16 (a) Informant Gilbert C. Forrester Sr.
(b) Address 3215 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948, at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-22 1948, and that I last saw him alive on 9-24 1948

Immediate cause of death Leucopenia and anemia — Duration

Due to Acute Leukemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G J Krauss for M.D.
Address Med. Dept. Date signed 9-24-48

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667089

667089

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Belle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALEXANDER ELLSWORTH STEHLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9509

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Nettie T. Stehley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1888

8. AGE: Years	Months	Days	If less than one day
59	10	11	hr. min

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business B & O R.R.

FATHER
12. Name Samuel Stehley
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Mary A. Fergusson
15. Birthplace Norfolk Va.

16 (a) Informant: Nettie T. Stehley
(b) Address 4022 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1948 (month, day, year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Kincaid
(b) Address 4204 Ridgewood Ave.

19 (a) SEP 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948, at 6.50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to multiple fractures

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-24-48 at approx. 6.30 A. M.
(b) Where did injury occur? North & Pennsylvania Aves
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury pedestrian struck by truck & auto

23. Signature [signature] M.D. Medical Examiner
Date signed September 24, 1948

Important: Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: Ardleigh Nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 5 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W 36 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas A Huser

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-7686

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 28-1871

8. AGE: Years 76 Months 9 Days 25 If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Stereotyper

11. Industry or business News Paper

FATHER
12. Name Nicholas Huser
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Annie J Huser
(b) Address 821 W 36 St.

17 (a) Burial (b) Date thereof 9-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Frank H Seiler
(b) Address 814 W 36 St.

19 (a) SEP 25 1948 (b) Washington Wilmington Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 48 to Sept 23 48 and that I last saw him alive on Sept 22 1948

Immediate cause of death
Cerebral hemorrhage
Cerebral sclerosis

Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry C Houck MD
Address 1727 W Mount Date signed Sept 24 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

67091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 67091

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Manna
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W.

6 (b) Name of husband or wife Robt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-1883

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robt. Henderson
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Rebecca —
15. Birthplace Lancaster Co. Va.

16 (a) Informant Hattie Manna
(b) Address 1426 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Russett Ave Baltimore Md

19 Filed SEP 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948 at 4:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Sept 22 1948 and that I last saw her alive on Sept 22 1948.

Immediate cause of death Cerebral hemorrhage. — Duration

Due to Hypertension. Chronic arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Carlson M. D.
Address 118 Edmondson Ave Date signed 9-25-48

VS 150

667092 M. - 95060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

667092 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Pitts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1878

8. AGE: Years 69 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Pitts
13. Birthplace Va.

MOTHER
14. Maiden Name Mattie ?
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Edw. G. Kelly
(b) Address 1303 Pleasant Man

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1948 at 2.15 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Sept 23 1948. and that I last saw h im alive on Sept. 23 1948.

Immediate cause of death: Pulmonary edema. — Duration: 2 days

Due to: Hypertensive arteriosclerotic Cardiovascular Disease. — 5 yrs.

Due to:

Other Conditions: Bronchopneumonia slight, bilat. — 5 days
(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature William H. Kuhns M.D.
Address Balto City Hosp Date signed 23 Sept 48

VS 150

667093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667093 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 ½ d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Andrae St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton M. Rasmussen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Martha L.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Mar 3 1872

8. AGE: Years	Months	Days	If less than one day
76	5	22	hr. min.

9. Birthplace Denmark
(Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business Varies

FATHER
12. Name (Unknown) Rasmussen
13. Birthplace Denmark

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frederick A. Rasmussen
(b) Address 452 Andrae St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1817 St. Paul St.

19 SEP 25 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 150 To be approved by Chief Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 22 1948 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1948 to 9/22 1948 and that I last saw him alive on 9/22 1948.

Immediate cause of death UREMIA
LOBAR PNEUMONIA, RIGHT
LOWER LOBE
Due to CHRONIC NEPHRITIS
Due to ARTERIOSCLEROSIS
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 9/15/48 at M
(c) Where did injury occur? BALTIMORE, MD.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work?
(Specify type of place)
(e) Means of injury: FELL DOWN STEPS

23. Signature Samuel B. Scalia M. D.
Address 20 E. Balto. St. Date signed 9/22/48

Certified by Frederick A. Rasmussen, Informant, 452 Andrae St., Balto., Md., Sept. 25, 1948

67094

BALTIMORE CITY HEALTH DEPARTMENT over 67094

CERTIFICATE OF DEATH 12 1a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 137 N. Patterson Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 137 N Patterson Park Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Annie B. Foltz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Arnold 1876

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 12 1867

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name George Lutz HERGET

13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna Eichorn

15. Birthplace Unknown

16 (a) Informant Miss Mildred Foltz

(b) Address 137 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Olivet St

18 (a) Funeral director J Heermann & Son

(b) Address 6067 HARFORD Rd

19 SEP 25 1948 (Date filed by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30- 1948 to 9-24- 1948, and that I last saw h alive on 9-24- 1948.

Immediate cause of death	Duration
Uremia	2 days
Due to Arteriosclerotic C V disease	2 years
Due to	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benj. B. Nunn M. D.

Address 4482 N Charles Ave Date signed 9-25-48

VS 150

92

667095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 667095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Kerry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT GRINER Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation auto mechanic

11. Industry or business

FATHER
12. Name Robert Griner Sr.
13. Birthplace Ga.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Robert Griner Jr III
(b) Address 336½ S. Ave. Newark, N. J.

17 (a) Burial (b) Date thereof 9/25/48.
(Burial, cremation, or removal)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) SEP 25 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 22 1948, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerulo Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Where at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 23 Sept 48

VS 151

667096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

667096 Registered No.

The cause of death must be entered as directed in the medical certification. Please answer all questions as completely as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Kenyon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK S. RUTTER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife: --

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18, 1869

8. AGE: Years	Months	Days	If less than one day
79	1	5	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Hand Painter

11. Industry or business: Purnell Art Galleries

FATHER
12. Name: Joseph H. Rutter
13. Birthplace: Md.

MOTHER
14. Maiden Name: Christina Gill
15 Birthplace: Maryland

16 (a) Informant: Mrs. Harry G. Rutter, sister-in-law
(b) Address: 3401 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1948 to 9-23-1948, and that I last saw him alive on 9-23-1948.

Immediate cause of death	Duration
Respiratory Failure due to Shock	
Due to Acute Failure	
Due to Malnutrition, Anemia, Cachexia	
Due to Carcinoma 2 Rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: William A. Warfield M D
Address Univ. Hosp. Date signed 9-23-48

VS 130

667097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 667097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 71, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora B. Weil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1864

8. AGE: Years 84 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Moritz H. Weil (D)
13. Birthplace Germany

MOTHER 14. Maiden Name Betty Gump (D)
15. Birthplace Germany

16 (a) Informant Miss Dora B. Weil
(b) Address Marlborough Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 2:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Sept 24 1948, and that I last saw her alive on Sept 24 1948.

Immediate cause of death: Intestinal Obstruction — Duration: 22 days

Due to: (Adeno carcinoma of Sigmoid (resected)

Due to: Post operative complications.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George P. Thomas M. D.
Address 33rd & Calvert Sts Balto 18
Date signed 9-24-48

VS 150

667098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G67098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 The Alameda
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Mary Thompson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Royal Oak, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Jean Feeser
(b) Address Taneytown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Sept. 1948 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. N. Hammond M.D.
Medical Examiner.
Date signed 24 Sept. 48

VS 191

667099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667099 Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Leaverton Cross

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo. Wilbur Cross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21st 1870

8. AGE: Years	Months	Days	If less than one day
78	3	3	hr. min.

9. Birthplace Kent Co. Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Charles Long
13. Birthplace England

MOTHER
14. Maiden Name Sarah Hopkins
15. Birthplace Harford Co. Maryland

16 (a) Informant Mrs Addie Lee
(b) Address 2010 Parish St Phila. Pa.

17 (a) Sept 27 1948 (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chester Cemetery
Location Kent Co. Maryland

18 (a) Funeral director W. W. Lewis Inc.
(b) Address 430 Edmondson Ave.

19 SEP 25 1948 (b) Huntington Williams M.D. (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24-48 19 at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-48 19 to 9-24-48, and that I last saw her alive on 9-24 19 48.

Immediate cause of death Coronary Thrombosis — Duration 4 days
Due to Generalized Arteriosclerosis —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M.D. M. D.
Address 541 S. Fulton Ave Date signed 9-25-48

VS 180

667100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Belgian ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Belgian ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA A. GILES

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife: Edward Hart Giles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1861

8. AGE: Years	Months	Days	If less than one day
87	6	--	hr. min.

9. Birthplace Westfield, N.J.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Henry Urmstone
13. Birthplace New Jersey

MOTHER
14. Maiden Name Emma Woods
15. Birthplace New Jersey

16 (a) Informant Mrs. Amy M. Searls
(b) Address 801 Belgian ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Episcopal
Location Old York Rd. & Greenmount ave.

18 (a) Funeral director Chas. E. Evans & Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) SEP 26 1948 (Date filed by registrar) (b) Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 24 1948.
and that I last saw her alive on Sept 23 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage Left	10 days
Due to Hypertension	3 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Fraley, M.D.
Address 2824 St. Paul St Date signed Sept 24-48

VS 150

667101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

667101 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Forest Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Samuel Whitaker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 91 | Months: 0 | Days: 28 | If less than one day: hr. - min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER 12. Name: Joshua Whitaker
13. Birthplace: Forest Hill Maryland

MOTHER 14. Maiden Name: Virginia Walker
15. Birthplace: Maryland -

16 (a) Informant: Elva Whitaker
(b) Address: Forest Hill Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28 48 (month) (day) (year)
(c) Cemetery or crematory: Mt Nathan Memorial Park
Location: Cooptown Harford Co

18 (a) Funeral director: Charles E Hunt
(b) Address: Jarrettsville Md

26 1948
(a) (b) Registrar
(Date rec'd by registrar)

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948 to 9-24 1948, and that I last saw h (illegible) alive on 9-24 1948

Immediate cause of death: Pulmonary embolism - origin - Iliac veins (?)
Due to
Due to
Other Conditions: Diabetes mellitus - Arteriosclerotic C.V. disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary embolism -

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: J. S. Sears M.D.
Address: Sanitary Bldg Date signed 9-25-48

111a

667102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

667102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster, Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Columbus Shean

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	widowed

6 (b) Name of husband or wife Mary C. Shean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Not known

8. AGE: Years	Months	Days	If less than one day
84	?	?	hr. min.

9. Birthplace Westminster Carroll Co. Md
(Town, county and state)

10. Usual Occupation retired laborer

11. Industry or business

FATHER
12. Name Dennis Shean
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Not known
15. Birthplace

16 (a) Informant Mrs. Laura Shean
(b) Address Charles St. Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)

(c) Cemetery ~~or Crematory~~ Ellsworth Cem.
Location Westminster Md.

18 (a) Funeral director J. E. Myers & Son
(b) Address Westminster Md.

SEP 26 1948
(Date rec'd by registrar)

(a) (b) Westminster Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948, to 9-25-48 19; and that I last saw him alive on 9-25-48 19

Immediate cause of death Arterio-sclerosis C.V. disease

Due to Contributing factors

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard D. Coon, M. D.

Address Date signed 9-27-48

VS 150

667103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 67103

512 G67103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson 4 (If outside city or town limits, write RURAL and give town)
(d) Street No. Sheppard Pratt Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Ross McClure Chapman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Mrs. Marion C. Chapman
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	11	hr. min.

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Supt. Sheppard Pratt Hosp
11. Industry or business:

FATHER
12. Name: Mr. Eugene Chapman
13. Birthplace: New York

MOTHER
14. Maiden Name: Agnes McClure
15. Birthplace: New York

16 (a) Informant: Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 27/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Henry McJenkins & Sons Co
(b) Address: 701 Park Ave

SEP 26 1948
(Date received by registrar)

(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1948, at 10:46 p M

21. I certify that death occurred on the date above stated; that I attended deceased from September 11 1948 to September 24 1948, and that I last saw him alive on 1948.

Immediate cause of death — Duration

(a) Carcinoma of prostate — 1 yr. 11 mos.
Due to
(b) Metastases to bones generalized — 4 mos.
Due to
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: John R. Smith, Jr. M.D.
Address: Union Memorial Hosp., Date signed: 9/27/48

G67104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Aronoff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose Mark
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 6 1896

8. AGE: Years	Months	Days	If less than one day
52	4	18	hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Samuel Aronoff
13. Birthplace Russia

MOTHER
14. Maiden Name Rebeccia Bellnowsky
15. Birthplace Russia

16 (a) Informant Rose Aronoff
(b) Address 3820 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof - - (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cmetry
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1114-16 W. Fayette Avenue

19 (a) 9-26-1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1948 at 1.30p M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1947 to Sept 24 1948 and that I last saw him alive on Sept 21 1948.

Immediate cause of death Coronary thrombosis — Duration Immediate death

Due to Arteriosclerosis — Duration 3 years +

Due to —

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St Date signed 9/27/48

VS 152

667105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

667105 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 416 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Lipsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Charles H. Lipsey
(b) Address 416 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1400 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Sept. 1948 at 3:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cirrhosis of Liver with Jaundice & hepatomegaly.
Due to Alcohol

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr M.D.
Medical Examiner
Date signed 25 Sept. 1948

VS 181

667106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 141 F

667106 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE HOFT Hoft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Newyork NY (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Newyork

MOTHER
14. Maiden Name Rose
15. Birthplace Newyork

16 (a) Informant Herman Hoft
(b) Address Kings Park N. Y

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place

SEP 26 1948 (Date rec'd by registrar) (b) Interator Baltimore, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1948, at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Septicemia
Acute Peritonitis
Due to Surgeon's Attempt

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at ? M.
(b) Where did injury occur? 1718 Fleet Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Criminal abortion

23. Signature [signature] M.D. (Medical Examiner)
Date signed 9/24/48

VS 151

CERTIFICATE CORRECTED 5-9-89

BALTIMORE CITY HEALTH DEPARTMENT

667107 Registered No. 667107

CERTIFICATE OF DEATH 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 Strickland St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Strickland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALFRED L. DONALDSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	218-22-3553	male	white	married

6 (b) Name of husband or wife Bertha E. Donaldson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 20, ~~1878~~ 1882

8. AGE: Years	Months	Days	If less than one day
~~79~~ 66	0	4	hr. min.

9. Birthplace Chester, Pa. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Bd. of Edu.-City of Balto.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mr. Wm. P. Webb
(b) Address 13 S. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
(Date rec'd by registrar) SEP 26 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1946 to 9/24 1948, and that I last saw h[illegible] alive on 9/23 1948.

Immediate cause of death Carcinoma of pancreas — Duration 2 mos

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation Sept 13, 1948

Major findings of operation: Ca of pancreas, metas- tasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Albert L. Donaldson M.D.
Address 2030 Wilbur Date signed 9/28/48

X

667108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54C

667108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. Wilson Place (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME C. Truman Lippy

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Pauline C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/3/05

8. AGE: Years	Months	Days	If less than one day
43	4	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Insurance Co.

FATHER
12. Name Irving Lippy
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Md.

16 (a) Informant Wife
(b) Address Frederick Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director W. R. Eichelberger, Sons
(b) Address Frederick Md

19 (a) [illegible] (b) [illegible]
(Date received by Registrar) [illegible] Registrar

SEP 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1948, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948, to 9/25 1948, and that I last saw him alive on 9/25 1948.

Immediate cause of death	Duration
Malignancy of Brain	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/24/48
Major findings of operation: Malignancy of brain
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Nicholas Mallas
Address University Hosp Date signed 9/25/48 M D

667109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

667109
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 W. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE PEARSON

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1943

8. AGE: Years 4 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Pearson
13. Birthplace Winnsboro, S.C

MOTHER
14. Maiden Name Charlotte Glenn
15. Birthplace Winnsboro, S.C.

16 (a) Informant: Charlotte Pearson (M)
(b) Address 1308 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Winnsboro, S.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

SEP 26 1948
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Spleen
Secondary Shock Peritonitis.

Due to

Other Conditions Healing Fracture of Left Femur
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at Approx. 3:30 P.M.
(b) Where did injury occur? In front of 1316 W. Lafayette Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Taxicab

23. Signature Earl L. Kaye M.D.
Medical Examiner.
Date signed 9-25-48

VS 1st

667110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

667110 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U. L. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Manor (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dohme (Grace A. Dohme)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Justus Dohme
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr) 9/28/1880
8. AGE: Years 68 | Months 11 | Days 28 | If less than one day hr. min.
9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name Malachy Etzler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Megley
15. Birthplace Md.

16 (a) Informant Ralph Justus Dohme
(b) Address 7310 Hamilton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 28 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn, Balto Co Md
18 (a) Funeral director E. Ellis Lamograux
(b) Address 4510 Liberty Heights Ave
19 (a) (Date rec'd by registrar) (b) Registrar
Washington Hill, Md.

SEP 26 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1948, at 11:4 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1948 to 9/25, 1948 and that I last saw h[illegible] alive on 9/26 1948

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Primary carcinoma of liver (cholangioma)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-14
Major findings of operation: as above
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney J. Venable, Jr. M.D. 40
Address St. Agnes Hospital Date signed 9-25-48

X

667111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. 667111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 B. Chapelgate Lane
(c) Hospital or institution: Pinecrest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Georges
(c) City or town Mt. Rainier (If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 - Bunker Hill Rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John J. Knowles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Telegraph Retired
11. Industry or business

FATHER
12. Name David A Knowles
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Hogan
15. Birthplace Baltimore, Md.

16 (a) Informant Charles P. Knowles
(b) Address 97 - Galveston St. S.W. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 29 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cemetery
Location Wisconsin Ave. Wash. D.C.

18 (a) Funeral director Wm. J. Malley
(b) Address 3200 - R.I. Ave - Mt. Rainier, Md

19 SEP 26 1948 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1948, at 7.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1948, to Sept. 26, 1948, and that I last saw him alive on Sept. 25 1948.

Immediate cause of death	Duration
CARDIAC Failure	24 hrs.
Due to MYOCARDIAL Degeneration	?
Due to ARTERIOSCLEROSIS	?
Other Conditions CHRONIC BRONCHITIS	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 9/20/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The name of informant should be carefully supplied.

G67112 ✓ G67112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 N. East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred A. Del Ciello

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0975

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose Del Ciello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1st 1888

8. AGE: Years	Months	Days	If less than one day
59	11	22	23 hr. min.

9. Birthplace Posso Lanciano Italy (Town, county, state)
10. Usual Occupation Forman
11. Industry or business Empire Contr. Co.

FATHER
12. Name Felice Del Ciello
13. Birthplace Italy

MOTHER
14. Maiden Name Marianna Martello
15. Birthplace Italy

16 (a) Informant Rose M. Del Ciello (Wife)
(b) Address 30 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) (Date rec'd by reg.) SEP 26 1948 (b) Huntington Williams M.D.

vs-155

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948 to Sept 23 1948, and that I last saw h[illegible] alive on Sept 23 1948

Immediate cause of death Glandular Carcinoma — Duration 3 months

Due to Carcinoma of Colon — 2 yr.

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation April 1947

Major findings of operation Carcinoma Colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature Harry Jardiner
Address 432 Belair Rd Date signed Sept 24 1948

Edna Kirkpatrick X

67113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Kimball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1879

8. AGE: Years 69 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER | FATHER
12. Name LeRoy Kimball
13. Birthplace Annapolis Md.
MOTHER
14. Maiden Name Annie Lant
15. Birthplace Annapolis Md

16 (a) Informant Laura A. Kimball
(b) Address 814 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director William Cook
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1948 to 9/26 1948, and that I last saw her alive on 9/25 1948.

Immediate cause of death Cardiac failure
Arteriosclerotic Heart Disease
Contributing cause

Due to Carcinoma - Cords of uterus
& adjacent tissues bifurcation

Due to Aorta OBLIQUE

Other Conditions Accessory Spleen
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: — Same - see above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.W. Winter M.D.
Address Church Home & Hosp. Date signed 9/26/48

USCO 153

67114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 927

67114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DON
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Paca (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John W. Cooke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11 1866

8. AGE: Years 82 | Months 2 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Terry Cooke
13. Birthplace Ireland

MOTHER
14. Maiden Name Helen (Unknown)
15. Birthplace Md.

16 (a) Informant: John T. Murphy
(b) Address 2315 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Park St.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/48 19 .. at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature John R. Weirs M.D. Medical Examiner
Date signed 9/24/48

VS 151

G67115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

120

G67115
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk Dr & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Garland GAY

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 219-10-7738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1925

8. AGE: Years	Months	Days	If less than one day
22	9	1	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Iceman

11. Industry or business Ice business

FATHER
12. Name Kendall Gay
13. Birthplace Va.

MOTHER
14. Maiden Name Connie Wright
15. Birthplace N.C.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal **(b) Date thereof** 9/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Roanoke Rapids
Location N. C.

18 (a) Funeral director Williams Funeral Home
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1948 **(b)** Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26, 1948 at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 5, 1948 to Sep 26, 1948, and that I last saw him alive on Sep 26, 1948.

Immediate cause of death	Duration
Glomerulo-nephritis, subacute, with uremia	unkn.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Vaccaro M. D.
Address Marine Hospital Date signed 9/26/48

V S 150

Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667116 BC - 48-18725 159

Registered No. 667116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5705 Belle Grove Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sandra Day #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced: S-n-g-l-e

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/48

8. AGE: Years | Months | Days | If less than one day: 11 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation New Born

11. Industry or business

FATHER
12. Name Julius Day
13. Birthplace Langston VA

MOTHER
14. Maiden Name Marcelline Wharton
15. Birthplace Baltimore Md

16 (a) Informant Mrs Marcelline Day
(b) Address 5705 Belle Grove Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School SEP 23 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 SEP 27 1948 (Date filed by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1948 at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 8/30 1948. and that I last saw h[illegible] alive on 8/30 1948.

Immediate cause of death: Immaturity — 2 hrs 11 hrs. — Duration

Due to ?

Due to

Other Conditions Aspiration of mucus?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 8-2-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

667117

Y8. 11872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

667117

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1218 N Fremont Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Dorethea Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race N

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/48

8. AGE: Years | Months | Days | If less than one day 16 hr. 47 min.

9. Birthplace Baltimore md
(Town, county, and state)

10. Usual Occupation N'Born infant

11. Industry or business

FATHER
12. Name Ramond Cornish
13. Birthplace Baltimore, md.

MOTHER
14. Maiden Name Martha Veney
15. Birthplace Baltimore Md

16 (a) Informant Mrs martha mason
(b) Address 1218 Fremont ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Sch SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address SEP 27 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 1948, at 12:47 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1948 to 7/17 1948.
and that I last saw h[illegible] alive on 7/17 1948

Immediate cause of death
Atelectasis ?

Duration

Due to Birth Drauma and respiratory distress

Due to Drauma of birth — complicate to corpore

Other Conditions
Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan O'Neill Kane M.D.
Address Provident Hosp. Date signed 7/18/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Type or print all items. Every item of information should be carefully supplied.

667118-3C-48-1958

BALTIMORE CITY HEALTH DEPARTMENT ✓ 667118

CERTIFICATE OF DEATH 160a.

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 N Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Woodrow Wilbon Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/48

8. AGE: Years	Months	Days	If less than one day
		1	18 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Ni Binn Infant
11. Industry or business

FATHER
12. Name Ernest Woodrow Wilbon
13. Birthplace Greensboro N.C.

MOTHER
14. Maiden Name Frances Gentry
15. Birthplace Dobson N C

16 (a) Informant Mrs Frances Wilbon
(b) Address 829 N Fulton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School SEP 23 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1948 at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1948 to 9/2 1948 and that I last saw him alive on 9/2 1948.

Immediate cause of death Massage internal bleeding at site undetermined.
Due to Probably injury at birth or congenital anomaly of hepatic vessels
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9-2

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

67139 48-19057 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 67139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 21 mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 W Saratoga St apt 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Smart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/48

8. AGE: Years	Months	Days	If less than one day
			hr. 21 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Born Dead Infant

11. Industry or business

FATHER
12. Name John Smart
13. Birthplace Camden SC

MOTHER
14. Maiden Name Orsinile Esther Moore
15. Birthplace Surrey Co Va

16 (a) Informant Mrs C. Esther Smart
(b) Address 817 W Saratoga St. apt 2

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 23 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 27 1948 (b) Lexington Williams MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1948 to Sept 5 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death (Pulmonary Atelectasis (Congenital)) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Banner M. D.
Address 722 N. Fulton Ave Date signed 9/8/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

667120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

667120 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Russell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William T. Riley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lillie

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1878

8. AGE: Years 72 | Months | Days 25 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Railroad

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant (Son) Thomas Riley
(b) Address 3812 Biddison Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc
(b) Address 718 Light St

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 at 9 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/21 1948 to 9/23 1948 and that I last saw h/ alive on 9/23 1948.

	Duration
Immediate cause of death CONFLUENT LOBAR PNEUMONIA	
Due to CIRCULATORY COLLAPSE	
Due to KREMLIN HYPERTENSIVE CARDIO-VASCULAR ARTERIOSCLEROTIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Oehm M. D.

Address 1 W. Penn Lane Date signed 9/24/48

VS 150

667121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

667121 Registered No.

Type or print in capital letters. Physicians: please write the causes of death clearly and legibly. All information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3658 Buena Vista Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3658 Buena Vista Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche P. Robertson

3 (b) If veteran, name war: –
3 (c) Social Security Account No. –

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Samuel E. Robertson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1889

8. AGE: Years: 59 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Hoover.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Bond.
15. Birthplace Maryland.

16 (a) Informant Dorothy Robertson
(b) Address 3658 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director Austin E. Donovan
(b) Address 3638 Roland Ave.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 2424 St. Paul St. Date signed Sept 28-48

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1948, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1931 to Sept 24 1948
and that I last saw h[illegible] alive on Sept 24 1948

	Duration
Immediate cause of death [illegible]	5 yrs
Due to [illegible]	
Due to [illegible]	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert M. Foster M.D.

VS 150

671122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 671122

GM. 123150

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 812 Harlem Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1885

8. AGE: Years	Months	Days	If less than one day
63	6	20	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George Payne

13. Birthplace MD.

MOTHER

14. Maiden Name Harriett Smith

15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 28 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore

18 (a) Funeral director Eugene H. Mayo

(b) Address 825 Harlem Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 24- 1948, at 2.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21- 1948, to 9- 24- 1948, and that I last saw him alive on 9- 24- 1948

Immediate cause of death Generalized miliary Tbc — Duration wks

Due to — Duration

Due to — Duration

Other Conditions post op sub total gastrectomy — Duration 4 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: miliary tbc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jordan Craft, M.D.

Address Balt. City Hosp. Date signed 9/25/48

VS 150

667123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667123

469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4338 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4338 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Tunney, Sr.

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-01-4480

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maud B. Tunney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 2, 1880

8. AGE: Years	Months	Days	If less than one day
68	3	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Marble Setter
11. Industry or business

FATHER
12. Name William Tunney
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Cashin
15. Birthplace Ireland

16 (a) Informant Mrs. Maud E. Tunney
(b) Address 4338 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 SEP 27 1948 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH September 24, 1948 at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to 9-24-1948, and that I last saw h[illegible] alive on 9-21-1948.

Immediate cause of death: Carcinoma of head & [illegible] Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Not done

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Tolman M.D.
M.D.
Address [illegible] Date signed 9-27-48

667124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore
(c) Hospital or institution: General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2353 annapolis Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thompson, Helen T.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife James L. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1879

8. AGE: Years	Months	Days	If less than one day
69	1	2 4/27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William Wastenhoffer
13. Birthplace Germany.

MOTHER
14. Maiden Name Catherine Dabus
15. Birthplace Germany.

16 (a) Informant Mrs. Emory Bell.
(b) Address 2353 Annapolis Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md

18 (a) Funeral director Jennie Cook Lyser
(b) Address 1600 N. North Ave.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Interment for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948 to 9-24 1948, and that I last saw her alive on 9-24 1948.

Immediate cause of death: Cerebrovascular hemorrhage left side of brain — Duration 6 days

Due to: Hypertensive atherosclerotic heart disease & cardiac enlargement — (Duration) (yrs)

Other Conditions: Acute arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Dann M.D.
Address W. Balto Gen. Hosp. Date signed 9-24-48

VS 150

G67125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Hudson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME G. WALLACE LANGDON

3 (b) If veteran, name war ------
3 (c) Social Security Account No. 212-14-3072

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary L. Langdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1871.

8. AGE: Years	Months	Days	If less than one day
77	8	0	hr. min.

9. Birthplace Orange Co., N.Y. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ? Langdon
13. Birthplace N.Y.

MOTHER
14. Maiden Name Elizabeth Pye.
15. Birthplace N.Y.

16 (a) Informant Melvin C. Langdon (Son)
(b) Address 3823 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location 7225 Eastern Ave.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1948 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Sept 23 1948. and that I last saw h~~im~~ alive on Sept 23 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidov M. D.
Address 3218 Eastern ave Date signed 9-24-48

VS 150

667126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

667126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2623 E. Oliver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle V. Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Van B. Davis
6 (c) If alive, give age 56 years

7. Birth date of deceased mo., day, yr. June 8, 1899

8. AGE: Years	Months	Days	If less than one day
49	3	16	hr. min.

9. Birthplace Feddore Nova Scotia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Alexander Day
13. Birthplace Feddore Nova Scotia

MOTHER 14. Maiden Name Matilda Mitchell
15 Birthplace Feddore Nova Scotia

16 (a) Informant Van B. Davis
(b) Address 2628 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/49 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem. Park
Location Taylor Ave.

18 (a) Funeral director John E. Miller Jr.
(b) Address 2435 E. Lafayette Ave, Baltimore, Md.

19 (a) SEP 27 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1946 to Sept 24 1949, and that I last saw h alive on Sept 24 1949.

Immediate cause of death Myocardial insufficiency
Due to Carcinoma, stomach
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
Signature Howard Jordan
Address 1513 N. Milton Ave Date signed Sept 26 1949

Howard Jordan M.D.

VS 15

667127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170c

667127
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALLAN HARRISON

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1923

8. AGE: Years 25 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: George W. Harrison
13. Birthplace: md

MOTHER
14. Maiden Name: Margaret Hatfield
15. Birthplace: md.

16 (a) Informant: Margaret Hatfield
(b) Address: Woodbine, md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month, day, year)
(c) Cemetery or crematory: Poplar Springs
Location: Poplar Springs, Howard Co. Md.

18 (a) Funeral director: C. M. Wells
(b) Address: Winfield, Md.

19 (a) SEP 27 1948 (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at 1:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-26-48 at Midnight M.
(b) Where did injury occur? Rt. 40, 1½ miles west of West Friendship, Howard County, Md.
(c) Did injury occur at home, work, farm, factory, public place? Public While at work? No
(d) Means of injury: Auto. & Auto. (Pass.)

23. Signature [signature] M.D.
Medical Examiner
Date signed 9-27-48

G67128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67128

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County

(c) City or ~~town~~ Jacksonville (If outside city or town limits, write RURAL and give town)

(d) Street No. 2311 Laurel Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Morris D. Wolfson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	married

6 (b) Name of ~~husband~~ or wife Sarah Goldberg

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) ~~2-2~~ 1884

8. AGE: Years	Months	Days	If less than one day
66	9	10	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation manufacturers-plumbing supplies

11. Industry or business

FATHER 12. Name Joseph Wolfson

13. Birthplace Russia

MOTHER 14. Maiden Name Dora Lippman

15. Birthplace Russia

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Rd., Balto 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/48 (month) (day) (year)

(c) Cemetery or crematory Jacksonville Florida

Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 124-26 W. North ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington for Williams, Mortician, The Seton Institute

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948, to 9-27 1948, and that I last saw him alive on 9-25 1948

Immediate cause of death	Duration
Pneumonia	2 days
Due to	
Due to Chronic urinary tract infection	4 yr.
Due to Mercurial poisoning	4 mo.
Other Conditions Complete heart Block	4 mo.
Cerebral injury	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. L. Meiers M. D.

Date signed 9/27/48

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The age is especially important.

667129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667129

1. PLACE OF DEATH Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address 2532 Boarman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip M Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-8857

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora M. Mae Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888.

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Insurance Co

FATHER
12. Name Louis Livingston
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Sidney Livingston
(b) Address 3731 Beehler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, (month) (day) (year)
(c) Cemetery or crematory Pikesville Jewish Cemetery
Location Bowleys Lane Herring Run

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N. North Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948, to Sept 27 1948, and that I last saw him alive on Sept 27 1948

Immediate cause of death coronary insufficiency — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Israel M. D.
Address Sinai Hosp - Balt Md Date signed 9-27-48

VS 150

Important: Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

667130

ES- 122159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

667130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 498 S. Caroline St.
8 days. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Wiggins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 15, 1912

8. AGE: Years	Months	Days	If less than one day: hr.	min.
36				

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Wiggins (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace N.C.

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof Sept. 28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy J. Wilson
(b) Address 1000 Beanty ave
(c) 1948 Huntington Williams, Mgr
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 (mo.) 48 (yr.) 11:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-16 48 to 9-23 48.
and that I last saw him alive on 9-23 48

Immediate cause of death For advanced
bilateral pulmonary
tuberculosis
Due to Tuberculous
abscesses prostate &
Due to testicle

Duration: 2 years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M D
Address Baltimore City Hosp Date signed 9-25-48

VS 150

657131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 657131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1834 N.Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N.Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel C.Blizzard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nellie E.Parlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1870

8. AGE: Years	Months	Days	If less than one day
77	10	11	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel C.
13. Birthplace N.J.

MOTHER
14. Maiden Name Rebecca Gandy
15. Birthplace N.J.

16 (a) Informant Nellie E.Blizzard
(b) Address 1834 N.Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ 28/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Olivet
Location Frederick Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 27 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948, at 8 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1948 to Sept 25 1948, and that I last saw h/ alive on Sept 25, 1948.

Immediate cause of death
Arteriosclerotic Cardiovascular disease

Due to

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7
2 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Eugene S. Blum
Address 1115 N. Calvert St. Date signed 9/25/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3671.32 ✓ 4 to a

Registered No. 1352

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1943 Annapolis ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs Anne Baer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Adam R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-7-1906

8. AGE: Years 42 | Months 4 | Days 19 | If less than one day: hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Etter

13. Birthplace Penna

MOTHER 14. Maiden Name Melinda Summers

15. Birthplace Penna.

16 (a) Informant Mr ADAM R BAER

(b) Address 1943 ANNAPOLIS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 30'48 (month) (day) (year)

(c) Cemetery or crematory GRINDSTONE HILL

Location CHAMBERSBURG - PA

18 (a) Funeral director Harry A Wirshe

(b) Address 4101 Edmondson ave

19 SEP 27 1948 (Date rec'd by registrar) (b) Printing for Williams Mfg

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948; at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7/48 to 9/26/48 and that I last saw h[illegible] alive on 9/26/48 7:

Immediate cause of death UREMIA → Duration 9 days

Due to Hydronephrosis

Due to Carcinoma of cervix with extension to pelvic organs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of cervix

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** Rafael D. Ramirez M. D.

Address Date signed

VS 150

Rafael D Ramirez ✓

6671133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

6671133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N Pulaski St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MRS EMMA V. LANG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife late Henry C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	11	2		99

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ridgeway
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Pettee
15. Birthplace Md.

16 (a) Informant Mrs Else Smallwood
(b) Address 504 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave

18 (a) Funeral director Harry A Witzke Jr.
(b) Address 4101 Edmondson Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Sept. 1948 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Sept. 1948 to 25 Sept. 1948 and that I last saw her alive on 25 Sept. 1948

Immediate cause of death Generalized Carcinomatosis — Duration: about

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph R Liberto
Address Bon Secours Hosp. Date signed 25 Sept 48

VS 150

3671134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 3671134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Knights of Columbus Club (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24, 1877

8. AGE: Years	Months	Days	If less than one day
71	7	2	hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Management Business

11. Industry or business

FATHER 12. Name Arthur L. Mitchell

13. Birthplace Mass

MOTHER 14. Maiden Name Lucy Angeli

15. Birthplace Italy

16 (a) Informant Miss Katherine Lederer

(b) Address 2903 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)

(c) Cemetery ~~Crematory~~ Loudon Park

Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1948 to 9/26 1948 and that I last saw h. m alive on 9/26 1948

Immediate cause of death Coronary Thrombosis ?

Duration

Due to Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Faraci M. D.

Address Md. Gen. Hosp. Date signed 9/26/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 549

673.35

Please write plainly and legibly. Use ink or indelible pencil.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4804 Edgar Terrace
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4804 Edgar Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Alexander G. Fedak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Dorothy Gayle Piper
6 (c) If alive, give age 30 years

7. Birth date of deceased mo., day, yr January 1, 1912

8. AGE: Years	Months	Days	If less than one day
36	8	24	hr. min

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Chemical Engineer
11. Industry or business Mutual Chemical Corp, 13 yr

FATHER
12. Name Gregory Fedak
13. Birthplace Austria

MOTHER
14. Maiden Name Eva Dran
15. Birthplace Austria

16 (a) Informant Mrs. Dorothy Gayle Fedak
(b) Address 4804 Edgar Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/40 (month) (day) (year)
(c) Cemetery ~~Sweetzer~~ Mount Hope, Location New York City

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 23 1940 (Date received by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1940, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22, 1940 to Sept 23 1940 and that I last saw him alive on Sept 15 1940

Immediate cause of death Rheumatic endocarditis — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(e) Means of injury

23. Signature M.D.
Address 54 S. Fulton Ave. Date signed

VS 150

667136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667136

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 N Calhoun

(c) Hospital or institution: Franklin Sq. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1217 N. Bentalou (If rural give location)

(e) Citizen of foreign country? Yes or (No)

If yes, name country

3 (a) FULL NAME Edwin F. Johnston

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-0616

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Bessie M. Johnston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 5, 1892

8. AGE: Years 56 | Months 4 | Days 19 | if less than one day: hr. min.

9. Birthplace: Philadelphia, Pa (Town, county, and state)

10. Usual Occupation: Asst Manager

11. Industry or business: F. S. Royster Guano Co.

FATHER

12. Name: Harry Johnston

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Mary Sigafoos

15. Birthplace: Bucks Co., Pa

16 (a) Informant: Bessie Johnston

(b) Address: 1217 N Bentalou, Balt

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 9/28/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar)

(b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 2:30 PM

21. I certify that I (last) attended deceased from 9-23 1948 to 9-24 1948, and that I last saw him alive on 9-24 1948

Immediate cause of death: Heart failure (Coronary thrombosis)

Duration: 6 mo.

Due to: Emphysema

Due to: Chronic tuberculosis

Other Conditions: Papilloma of bladder.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq. Hosp. Date signed 9-24-48

VS 150

Please write the causes of death clearly and legibly.

67137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

67137 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Lakeside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Lakeside Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JOHN H. FERGUSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Clara Ferguson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	8	7		

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: President
11. Industry or business: Monumental Printing Co.

FATHER
12. Name: John H. Ferguson
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Ida Rathell
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. John H. Ferguson
(b) Address: 7 E. Gittings Ave.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, at 5:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 1-1-1940 to 9-25-1948 and that I last saw h[im] alive on 9-25-1948.

Immediate cause of death
Due to: Cerebral hemorrhage — Duration: 1/2 hour
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury:

23. Signature: Howard H. Adams M.D.
Address: 7 W. Preston Date signed 9-27-48

VS 150

G67138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

✓ G67138 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4208 Berger Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Berger Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LILLIAN MAY BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife German W. Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 30, 1893

8. AGE: Years	Months	Days	If less than one day
55	7	25	hr. 4 min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eli Sheppard
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Annie Ray
15. Birthplace Howard Co., Md.

16 (a) Informant Mr. German W. Bowen
(b) Address 4208 Berger Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Mountain View Cem.
Location Alpha, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Certificate filed [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1948, to Sept 25 1948, and that I last saw her alive on Sept 25 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4d
Due to Nephritis 3 years and Hardening	
Due to	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ed Stevens M.D.
Address 2878 Liberty Rd Date signed 9-27-48

VS 150

67189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIE E. FOARD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband Charles H. Or. Foard
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec. 17, 1864

8. AGE: Years 83 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edwin Chance
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie Barnshaw
15. Birthplace Martinsburg W. Va.

16 (a) Informant Mrs. Edna L. Rupfield
(b) Address 32 E. 25th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director W. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) SEP 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945, at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1923 to 9/24 1945, and that I last saw [illegible] alive on 9/24 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to: Hypertension — 5 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 9/27/45

VS 150

66714O

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12 12

Registered No. 66714O

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 N. Monastery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Monastery ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JOHN A. HAYNIE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-01-9153

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosa Etta Haynie (nee Walker)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1874

8. AGE: Years: 73 | Months: 9 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Edwin L. Haynie
13. Birthplace: Va.

MOTHER
14. Maiden Name: Margaret Berry
15. Birthplace: Va.

16 (a) Informant: Mrs. Rosa E. Haynie
(b) Address: 141 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Mem. Pk.
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948, at 4:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept. 26 1948. and that I last saw him alive on Sept. 26 1948.

Immediate cause of death — Duration

Pulmonary Tuberculosis — ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature J. H. Mason M.D.
Address 617 N. York St. Date signed 9/27/48

VS 150

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67141 ✓ 67141

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Provident Hospital

(c) Hospital or institution: 1514 - Division St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1103 - W. Lanvale (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Kate Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1888

8. **AGE:** Years 60 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Charles Co. Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Sayer

13. Birthplace Charles Co. Md.

MOTHER

14. Maiden Name Anne Sayers

15. Birthplace Charles Co. Md.

16 (a) Informant Louise Robinson

(b) Address 2712 Bookert Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Star Cem.

Location

18 (a) Funeral director Mrs Katie A Williams

(b) Address 322 N Schroeder St

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 48 at 10 40 P M

21. I certify that death occurred on the date stated, that I attended deceased from 9-24 19 48 to 9-24, 48 and that I last saw h[illegible] alive on 9-24 19 48

Immediate cause of death Cerebral vascular accident — Duration

Due to M. Hypertension

Due to

Other Conditions

CERTIFICATION APPROVED BY

Thos. S. Mercer, M.D.

CHIEF OR ASST. MEDICAL EXAMINER

M. D.

(Lacunae [illegible] pregnancy with last months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged finally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 9-27-48

VS 150

667142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2856 Harford Road
(c) Hospital or institution: 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2856 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Franklin Leroy Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary A. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1st, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Poultry Business (Ret.)
11. Industry or business

FATHER
12. Name Wm. L. Wilson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annabelle Preston
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary B. Wilson
(b) Address 2856 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 SEP 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1948 to Sept 25 1948, and that I last saw him alive on Sept 24 1948.

Immediate cause of death	Duration
Acute Cardial Decompensation	2 mo.
Due to Arterio sclerosis	20 yrs.
Due to Cerebral Hemorrhage Paralysis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred. J. Fanning M.D.
Address 2858 Harford Rd Date signed 9/27/48

VS 150

667143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667143

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL ~~RESIDENCE~~ OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Willis
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marian W. Harbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-3482

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married~~ widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 24 1926

8. AGE: Years 21 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace (Town, county, and ~~state~~)

10. Usual Occupation Typist

11. Industry or business

FATHER 12. Name EZRA W HARBAUGH
13. Birthplace WESTMINSTER, MD.

MOTHER 14. Maiden Name MARY C NEWMAN
15. Birthplace WESTMINSTER, MD

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 30 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ RIDERS CEMETERY
Location NEAR WESTMINSTER MD

18 (a) Funeral director JOHN R. BYERS
(b) Address WESTMINSTER, MD.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1948 at 12 55 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/25 1948 to 9/27 1948 and that I last saw h~~e~~r alive on 9/27 1948

Immediate cause of death: Respiratory Failure — Duration
Due to Acute Coma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Blanchard M.D.
Address Maryland General Hospital Date signed

667144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

667144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Calvert
(c) Hospital or institution Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Canterbury Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Chambers Van Lear

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jno. Findlay Van Lear
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 21 1872

8. AGE: Years 76 | Months 4 | Days 5 | If less than one day: hr. min.

9. Birthplace Chambersburg Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Geo. B. Chambers
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden Name, Emily Bright
15. Birthplace Pottstown, Pa.

16 (a) Informant Emily F. Van Lear (daughter)
(b) Address 3927 Canterbury Rd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-48 (month) (day) (year)
(c) Cemetery or crematory River View
Location Williamsport - Md

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. STEWART SUC.) 100 W. NORTH AVENUE
(b) Address Huntington Williamsport, Md

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/26 1948 to 9/26 1948 and that I last saw h[er] alive on 9/26 1948

Immediate cause of death: Cerebrovascular accident — Duration: 8 hrs ?

Due to: Arteriosclerosis

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(e) Means of injury

23. Signature H. Russell Hoop, M. D.
Address Baltimore Md. Date signed 9/26/48

VS 150

G67145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67145

X 162a

Typewriting necessary. Physicians: please write the causes of death clearly and legibly. The items must be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Baby maloney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/20/48

8. AGE: Years	Months	Days	If less than one day
			3 hr. 48 min.

9. Birthplace University Hosp - Balto - Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Paul Maloney
13. Birthplace Dayton Md.

MOTHER
14. Maiden Name Edna Irene Burth
15. Birthplace Woodbine, Md

16 (a) Informant Irene B. Maloney
(b) Address Mt. Airy, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory [redacted] SEP 24 1948
Location

18 (a) Funeral director [redacted]
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948, at 3:48 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 9-21 1948, and that I last saw h[illegible]m alive on 9-21 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Intracranial Hemorrhage?

Due to Erythroblastosis Fetalis

Other Conditions Hepatosplenomegaly
Splenomegaly, Clinical ... duct
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address University Hosp Date signed 9-21-48

VS 150

657146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657146

160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore ~~Baltimore~~ Essex
(c) City or town ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Dorsey ave
(If rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy Ann Weidinger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 9-19-48

8. AGE: Years | Months | Days 1 | If less than one day 14 hr. 13 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John George Weidinger
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Merriken
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Weidinger
(b) Address 527 Dorsey Ave - Essex, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Public Hospital School SEP 24 1948
Location

18 (a) Funeral director Deputy Director of Health
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948, to 9/21 1948, and that I last saw her alive on 9-21 1948.

Immediate cause of death: Respiratory failure — Duration

Due to Atelectasis

Due to Infantile Pneumonia.

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Jos. Christley Jr. M.D.
Address Franklin Sq. Hosp. Date signed 9/21/48

VS 150

1

147

BC-48-20493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

✓ 667147

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City Maryland

(b) Street address Fayette & Calhoun Sts.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38hr.

(e) Length of stay in Baltimore (yrs., mos., or days) 38hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 629 N. Calvert St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Grimes

3 (b) If veteran, name war ✓

3 (c) Social Security Account No ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	✓

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-48

8. AGE: Years | Months | Days | If less than one day 38 hr. 20 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER 12. Name Henry Samuel Grimes

13. Birthplace Clarksville Md.

MOTHER 14. Maiden Name Doris Biel

15. Birthplace Baltimore, Md.

16 (a) Informant Doris Grimes

(b) Address 629 N. Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School SEP 27 1948

Location Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Evergreen Cemetery, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1948 to 9-23 1948, and that I last saw him alive on 9-23 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to Cerebral hemorrhage	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Churchill Jr. M.D.

Address Franklin Sq. Hosp. Date signed 9/23/48

VS 150

G67148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G67148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 Clipper Heights Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Clipper Heights Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jane Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8, 1868

8. AGE: Years 80 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Malachi Lee
13. Birthplace North Carolina

MOTHER
14. Maiden Name Alice Hardy
15. Birthplace North Carolina

16 (a) Informant John Edward Lee
(b) Address 3921 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 27 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 26, 1948 at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 Sept 26 1948 and that I last saw her alive on Sept 26 1948

Immediate cause of death Arteriosclerotic (CVD
C. Decomp.

Duration 7

Due to

Due to

Other Conditions Possible Ca. Rectum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Kinnamon M. D.
Address 371 Dall Pl Date signed 9-27-48

VS 159

G67149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 925

G67149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 Bartlett Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED;
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Bartlett Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pauline Elinor Hockenberry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elmer W. Hockenberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1904

8. AGE: Years 44 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Steelton, Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Albert Morrett
13. Birthplace Vermont

MOTHER 14. Maiden Name Margaret Beauplon
15. Birthplace Vermont

16 (a) Informant Elmer W. Hockenberry
(b) Address 737 Bartlett Avenue

17 (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Churchtown
Location near Carlisle, Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 27 1948 (Date rec'd by registrar) Curtis Bay Williamsport, Md.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 26, 1948, at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Aug 1948, to 26 Sep 1948.
and that I last saw h[illegible] alive on 24 Sep 1948

Immediate cause of death Coronary occlusion — Duration Immed

Due to Hypertensive heart disease — 5 years +

Due to

Other Conditions Post coronary occlusion on 5 Aug 48
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M D
Address 2020 N. Charles St Date signed 27 Sep 48

VS 150

667150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 East Lorraine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. Lorraine Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN AMBROSE HUNT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pearl Suter Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer, Diamond Cab.
11. Industry or business

FATHER
12. Name Thomas Hunt
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Kelly
15 Birthplace Md.

16 (a) Informant Mrs. Pearl Hunt
(b) Address 301 E. Lorraine Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/48 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 45 to Sept 25 19 48, and that I last saw h[illegible] alive on Sept 23 19 48.

Immediate cause of death Cerebral thrombosis — Duration 2 min
Due to arteriosclerosis — 1 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Egbert K. Mortimer Jr
Address 2706 St Paul Date signed 9/27/48 M D

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67151 | 12 B | Registered No. G67151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 East Clement Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 East Clement Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Ray Ritter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha A. (La Barre)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) II/28/1904

8. AGE: Years	Months	Days	If less than one day
43	9	27	hr. min.

9. Birthplace Hagerstown, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Sierra Lumber Company

FATHER
12. Name William H. Ritter
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary G. Shimp
15. Birthplace Virginia

16 (a) Informant Family
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Avenue

18 (a) Funeral director Samuel L. McCauley
(b) Address 130 East Fort Avenue

SEP 27 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Sept 24 1948 and that I last saw him alive on 24 1948.

Immediate cause of death: Cerebral Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel L. McCauley M. D.
Address 203 Valley Date signed 9/27/48

X

G67152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67152 Registered No.

BC- 48-20676 157M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County WORCESTER
(c) City or town SNOW HILL (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 FEDERAL ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME BABY "ALBERTA" HARRIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-25-48

8. AGE: Years	Months	Days	If less than one day
—	—	2	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER
12. Name EDWARD HARRIS
13. Birthplace Md.

MOTHER
14. Maiden Name ALBERTA WILLIAM
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 28 1948 (month) (day) (year)
(c) Cemetery or crematory Woodcock
Location Snow Hill Md.

18 (a) Funeral director Lilley & Barnes
(b) Address Snow Hill Md

19 (a) SEP 28 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948, to 9-27 1948, and that I last saw her alive on 9-27 1948.

Immediate cause of death: Prematurity — Duration

Due to Tumor of Heart?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Autopsy Tumor of Heart (type undetermined)
of autopsy? ↑

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Eugene I. Goldstein M. D.
Address Johns Hopkins Hospital Date signed 9/27

VS 159

67153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Seni Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Md Route 7 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. Marshall MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Charlotte S. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1919

8. AGE: Years	Months	Days	If less than one day
28 29	10	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name John A. Mason
13. Birthplace Md.

MOTHER
14. Maiden Name Florence A. Spath
15. Birthplace Md.

16 (a) Informant Mrs. J. A. Mason
(b) Address Route #7 Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cemetery
Location Westminster, Md.

18 (a) Funeral director C. O. Fuss & Sons
(b) Address Taneytown, Md.

19 SEP 28 1948 (Date rec'd by Local Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept 1948, at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Sept 1948, to 27 Sept 1948, and that I last saw him alive on 27 Sept 1948.

Immediate cause of death Cardio-resp. failure — Duration

Due to severe bleeding ulcer

Due to pulmonary tbc - active miliary tbc -

Other Conditions G.U. tbc advanced

(Include pregnancy within 3 months of death)

Date of operation (1942)

Major findings of operation: Tb Kidney

of autopsy: advanced miliary tbc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Sokale M.D.
Address Seni Hospital Date signed 28 Sept 48

VS 150

667154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

667154
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Beck Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Howard V. Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1879

8. AGE: Years	Months	Days	If less than one day
68	10	18	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm H. Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Snyder
15. Birthplace Balto. Md.

16 (a) Informant: Howard V. Hunt
(b) Address 2027 E. Preston St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (Date rec'd by registrar) SEP 28 1948 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27th 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Sept 27 1948, and that I last saw her alive on Sept 26 1948.

Immediate cause of death: Cerebral hemorrhage. Duration 1 hr 5/48
Due to Chronic Hypertension (arterial)
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which) (Name)
(e) Means of injury —

23. Signature John F Hemmeter M.D.
Address 722 N Arlington Ave Date signed Sept 27/48

VS 130

667155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667155

GN. 87932

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
B ltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eunice Ely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? Nov. 13

8. AGE: Years	Months	Days	If less than one day
66?	10	12	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Enosh Ely
13. Birthplace Conn.

MOTHER
14. Maiden Name Victoria Walters
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director A. McClain Cook Inc.
(b) Address 1223 E. Saint St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 26 - 1948 at 6.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 10 - 1944 to 9- 26- 1948 and that I last saw h er alive on 9-26- 1948

Immediate cause of death: aspiration pneumon.
Duration: 2 days

Due to: Arteriosclerosis generalized.

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinton Jr. M.D.
Address Balto City Hosp Date signed 9-28-48

VS 150

67156 NEENAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. 67156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 2days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Hudson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Neenan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Thomas A. Neenan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1907

8. AGE: Years	Months	Days	If less than one day
40	11	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John S. Burk
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Nora E. Johnson
15. Birthplace Balto. Md.

16 (a) Informant Vivian Neenan
(b) Address 2900 Hudson st.

17 (a) Burial (b) Date thereof 1/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. G. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) SEP 28 1948 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 6:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Sept 26 1948 and that I last saw h alive on Sept 26 1948.

Immediate cause of death Septicemia — Duration

Due to Liver abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 1, 1948

Major findings of operation: Chron
Completely [illegible] [illegible]
Autopsy 68 ; duodenum
of autopsy: Liver abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan H Mould M.D.
Address Sinai Hosp Date signed Sept 28 1948

VS 150

G67157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G67157
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Fauvens Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Fauvens Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Agnes Ralls
(b) Address 46 N St S.W. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director J. Brooks
(b) Address 1463 Carey St.

19 SEP 28 1948 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to Sept 26 1948 and that I last saw her alive on Sept 24 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Broken Compensation	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature E. William Frey, M.D.
Address 1928 Penna Ave Date signed Sept 27/48

VS 150

6[illegible]158 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

Registered No. 66758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER GRIER, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Mozella —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 45 | Months | Days | If less than one day: hr. min.

9. Birthplace Cleveland, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alex. Grier
13. Birthplace N.C.

MOTHER
14. Maiden Name Laura —
15. Birthplace

16 (a) Informant Mozella Grier
(b) Address 809 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28-48 (month)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Adams
(b) Address 142 N. Broadway

19 SEP 28 1948 (Date rec'd by registrar) Carrington Williams, MD

VS 551

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948, at 6:00 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Dilatation Hypertrophy of Heart
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryle M.D.
Medical Examiner
Date signed 21 Sept 48

67159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 67159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. SPEARS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1876

8. AGE: Years	Months	Days	If less than one day
64	10	13	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace Virginia

MOTHER 14. Maiden Name ?

15. Birthplace Virginia

16 (a) Informant Ross Nowlin

(b) Address 229 Bishop Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halsteadt

(b) Address 918 Druid Hill Ave.

19 SEP 28 1948 (Date received by registrar) Washington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at 12.15 a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil L. Ryan M.D. (Medical Examiner)

Date signed September 25, 1948

VS 151

CERTIFICATE CORRECTED 11-8-49 ✓ 667160

667160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
Stoney Run Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town La Plata
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (illegible) Vernon Padgett

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife: Pearl Isola

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 23-1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	1	4		

9. Birthplace La Plata Md
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name (illegible) Padgett
13. Birthplace Johns Co. Md

MOTHER
14. Maiden Name (illegible) Roberta Tucker
15. Birthplace

16 (a) Informant Francis Padgett
(b) Address Waldorf Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (illegible) 30 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Rest
Location La Plata Md

18 (a) Funeral director Hewitt + Ryan
(b) Address Waldorf Md

19 (a) SEP 28 1948 (Date received by local registrar) (b) Huntington Williams 42 (Signature of local registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 1.20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948 to Sept 27 1948, and that I last saw ... alive on Sept 27 1948

Immediate cause of death	Duration
Cardio-Myopatory Failure	
Due to Coronary occlusion	
Due to Arteriosclerotic Cardio-Vascular disease, Chronic myocarditis	
Other Conditions	

(Include pregnancy within 3 mos. of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland E. Day M.D.
Address 4-E 33rd St
Date signed Sept 27, 1948

VS 150

67161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 667161

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2075 Rockrose Ave.

(c) Hospital or institution:

Ardleigh Nursing Home. 12-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 832 W. 34th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henry Roy Rodgers.

3 (b) If veteran, name war ---------

3 (c) Social Security Account No. 212-10-7262

4. Sex: Male.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Mattie I. Rodgers.

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1881

8. AGE: Years 67 | Months - | Days 3 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Machinist.

11. Industry or business Balmar Corp.

FATHER 12. Name Benjamin F. Rodgers.

13. Birthplace Md.

MOTHER 14. Maiden Name Julia A. Wilhelm.

15. Birthplace Md.

16 (a) Informant Mattie I. Rodgers.

(b) Address 832 W. 34th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept, 29, 48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn, Md.

Location Woodlawn, Md.

18 (a) Funeral director Paul E. Chenoweth Jr.

(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 28 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948, at 11p M

21. I certify that death occurred on the date above stated, that I attended deceased from July 10 1948 to July 26 1948, and that I last saw him alive on July 26 48.

Immediate cause of death Bronchopneumonia — Duration 2 weeks

Due to Carcinoma of prostate — Duration July 10/48

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 29/48

Major findings of operation: Carcinoma of prostate

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leonard Wellington M. D.

Address 848 W 36th Date signed 9/27/48

VS 150

67162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G67162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 N. Bentlou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 N. Bentlou St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William Weber

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 21, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Payroll Clerk
11. Industry or business Dreyer Box Company

FATHER
12. Name Henry Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Elgert
15. Birthplace Germany

16 (a) Informant Miss Ruth E. Jaeger
(b) Address 1012 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) SEP 28 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1948 at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Sept 26 1948.
and that I last saw h alive on Sept. 26 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1/2 hour
Due to Arterio sclerotic type heart disease with Adiac.	3 years
Due to Enlargement + hypertension	
Other Conditions Angina pectoris	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 27 1948

67163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

✓ G67163

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 McELDERRY ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME ANDREW James NEUBERGER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of ~~husband~~ or wife Margaret Ulrich

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) FEB 2, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	24	hr. ____ min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER
12. Name THOMAS NEUBERGER
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name CATHERINE LEIMKUHLER
15. Birthplace BALTO, MD

16 (a) Informant EDWARD NEUBERGER
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Moreland Memorial Park
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St., Balto. Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 SEPT 1948 at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 20AUG 1948 to 26SEPT 1948. and that I last saw HIM alive on 26 SEPT 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	2 HOURS
Due to CHRONIC FIBRO-CASEOUS PULMONARY TUBERCULOSIS WITH CAVITATION, RIGHT LUNG	ABOUT 7 YEARS.
Due to	
Other Conditions MARKED CACHEXIA	6 MOS.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of ~~operation~~ AUTOPSY • DENSE PLEURAL ADHESIONS WITH A LARGE PUS FILLED CAVITY IN RIGHT UPPER LUNG

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Donald F. England
Address Maryland Gen. Hosp. Date signed 26 Sept 48

VS 150

X

67164 M269-0

G67164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 N. Mulberry St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Adolph Ludwig

(a) Residence: No. Emmittsburg Md St., Ward. Frederick Co.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertrande Hagler Ludwig

6. DATE OF BIRTH (month, day, year) March 25, 1858

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
90	6	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Bertrande Ludwig

(Address) Emmittsburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Emmittsburg Md Date Sept 30 1948

19. UNDERTAKER S. L. Allison

(Address) Emmittsburg Md.

20. FILED SEP 28 1948 Emerson Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 28, 1948

22. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1948 to Sept 28, 1948

I last saw h/ alive on Sept 27, 1948 Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	9/20/48

Other contributory causes of importance:

Arteriosclerosis

Hypertension

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify No

(Signed) S. L. Allison M. D.

(Address) 332 Frederick St

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67165 / 1242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 Laurnes St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 Laurnes St.
(If rural give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country ********

3 (a) FULL NAME ELEANOR ~~ELANOR~~ REED MEEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Thomas J. Meehan
6 (c) If alive, give age **years

7. Birth date of deceased (mo., day, yr.) Not obtainable

8. AGE: Years	Months	Days	If less than one day
About 49	***	**	** hr. ** min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ****** Reed
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Margaret Coyle
15. Birthplace Ireland

16 (a) Informant Mrs. James A. Travis
(b) Address 7512 Berkshire Road Z 24

17 (a) Burial (b) Date thereof 9/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street

19 (a) SEP 28 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948, at 8:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of liver
Esophageal varices

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Morell M.D.
Medical Examiner.
Date signed 9/27/48

VS 151

ATION APPROVED BY Vital Statistics Section
67166 Earl L. Klug M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 667166

Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 18 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bishop Rd, Baltimore 18 Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LELIA S. ALVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband ~~or wife~~ J. Richard Mc. Alvey
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
88	11	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

PARENTS
12. Name Martin Scott (D)
13. Birthplace Virginia
14. Maiden Name Pocahontas Bernard (D)
15. Birthplace Virginia

16 (a) Informant Martin S. Alvey
(b) Address 1 W. Bishop Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory
Location Dry Mount Va.

18 (a) Funeral director H. W. Mears and Son
(b) Address 505 N. Calvert St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1948, at 7 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948, to Sept 26 1948, and that I last saw her alive on Sept 26 1948.

Immediate cause of death Pulmonary embolus — Duration

Due to

Due to INTERNAL HAEMORRHAGE

Other Conditions Pulmonary edema. Intertrochanteric fracture Lt. femur
(Include pregnancy within 3 months of death)

Date of operation 9/20/48

Major findings of operation: Intertrochanteric fracture left femur

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 121
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 14 at M
(c) Where did injury occur? home.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury fall (slipped and fell to floor)

23. Signature Charles N. Watt, Jr. M. D.
Address Union Memorial Hosp. Date signed 9/27/48

VS 150 To be signed by Medical Examiner

57167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. G67167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Ausquith Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Ausquith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma H. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1875

8. AGE: Years	Months	Days	If less than one day
73	2	24	hr. min.

9. Birthplace Ellicott City Howard County Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Heblones
13. Birthplace Lancaster County Va

MOTHER
14. Maiden Name Lizzie
15. Birthplace Ellicott City Maryland

16 (a) Informant Mrs C. Demby
(b) Address 729 N Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore City Md

18 (a) Funeral director Joseph A Lucy
(b) Address 66 West Baltimore St

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) [illegible] Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 24 1948.
and that I last saw [illegible] alive on Sept 22 1948.

Immediate cause of death Coronary Occlusion and Myocardial Degeneration
Due to Hypertension and Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 3 months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. O. Stewart M. D.
Address 1032 N Fremont Ave Date signed Sept 29

VS 150

67168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906½ Preice St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 906½ Preice St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie Lipscomb.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Aaron Lipscomb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1884

8. AGE: Years: 64 | Months: 6 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Essex County, Virginia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Randall Roane.
13. Birthplace: Essex County, Va.

MOTHER
14. Maiden Name: Catherine
15. Birthplace: Essex County, Va.

16 (a) Informant: Rebecca Nicholson
(b) Address: 454 Manhattan Apts. N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: Mrs. Victor A. Williams
(b) Address: 322 N. Schroeder St.

19 SEP 28 1948 (Date received by Registrar) (b) Huntington, Indiana

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 48, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1948 to Sept 19 1948 and that I last saw h alive on Sept 19 1948

Immediate cause of death: Cardiac Renal

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address: [illegible] Date signed: 9/27/48

VS 150

Wm. M. Hatter

7169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 67169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 866 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 866 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Co

6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife: Blanche Stephens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 17, 1893.

8. AGE: Years: 54 | Months: 10 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Appomattox Co., Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Paul Stephens.
13. Birthplace: Appomattox Co. Va.

MOTHER
14. Maiden Name: Katie Isabelle
15. Birthplace: Appomattox Co. Va.

16 (a) Informant: Mrs. Katie Stephens.
(b) Address: 866 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: Mrs Katie A. Wilkinson
Address: 322 N. Schroeder St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/26 1948, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948 to 9/26 1948.
and that I last saw h alive on 9/26 1948.

Immediate cause of death: Coma Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: B. Wilkerson M. D.
Address: 2479 W. Lee St. Date signed

VS 150

67170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 E Henrietta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Henrietta
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jamar M. Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-1539

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 10/11/1924

8. AGE: Years 23 | Months 11 | Days 18 | If less than one day hr 14 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Mayer Dept Store

FATHER
12. Name Clarence Morgan
13. Birthplace Md

MOTHER
14. Maiden Name Nancy J Martin
15. Birthplace Pa

16 (a) Informant Mr Clarence Morgan
(b) Address 9 E Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director J. J. Lynch & Sons
(b) Address 318 Light St

19 (c) SEP 28 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept. 1948 at 8:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 24 Sept 1948 to 26 Sept 1948. and that I last saw h[illegible] alive on 25 Sept 1948.

Immediate cause of death Chronic nephritis
Malignant Hypertension

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. B. Ellison M. D.
Address 107 E. Madison Date signed 27 Sept 48

VS 15)

67:71 BC-KP-1966 BALTIMORE CITY HEALTH DEPARTMENT ✓ 67:71

CERTIFICATE OF DEATH

159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Child born en U.M.H.T. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3152 Keswick Road (If rural give location) Was never discharged
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Daniel Slater

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Infant.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/13/48

8. AGE: Years | Months | Days: 15 | 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Harry Slater
13. Birthplace

MOTHER
14. Maiden Name Geraldine Slater
15 Birthplace

16 (a) Informant Geraldine Slater
(b) Address 3152 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Lot 11, Block 6

18 (a) Funeral director C. Howard Evans
(b) Address 1400 St. Charles Ave

19 SEP 28 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1948, to 9/27 1948, and that I last saw him alive on 9/27 1948.

Immediate cause of death	Duration
Cardio respiratory failure	2 days
Due to atelectasis	15 days
Due to Prematurity	15 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Catherine F. Young M. D.
Address Union Memorial Hospital Date signed 9/27/48

VS 159

CERTIFICATION APPROVED BY
Lieutenant for Commissioner
John R. Travis M.D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667172

1. PLACE OF DEATH. MEDICAL EXAMINER.
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 mins
(e) Length of stay in Baltimore (yrs., mos., or days) about 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 618 Collett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Kelley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Negro
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice Kelley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 1908
8. AGE: Years 39 40 | Months 11 | Days | If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Kelley
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Allen
(b) Address 618 Collett St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Wakefield Va
Location Va
18 (a) Funeral director George B. Nelson
(b) Address 1303 Pennsylvania Ave
19 (a) 9-28-1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24/1948 at 7 00 PM
21. I certify that death occurred on the date above stated, that I attended deceased from 9/24 1948 to 9/24 1948, and that I last saw him alive on 9/24 1948.
Immediate cause of death Pulmonary Edema
Due to Acute heart Failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address Standard Hosp Date signed 9-27-48

VS 180

667173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

667173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1066 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1066 Fremont Ave
(If rural give location)
(e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME Charles C. McElderry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24

8. AGE: Years 76 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name unk
13. Birthplace Maryland

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant B. E. Smith
(b) Address 2238 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Druidman

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1948 to 9/27 1948.
and that I last saw h alive on 9/26 1948.

Immediate cause of death
Chr. Myocarditis
C. Decompensation —
Due to

Due to

Other Conditions Arteriosclerosis + Hypertension.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration 2 yrs +

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas A Julian M.D.
Address 511 N Eutaw St Date signed 9/28/48

VS 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 1671174

1671174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luerine Johnson
LUERINE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Robert Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1909

8. AGE: Years	Months	Days,	If less than one day
39	4		hr. min.

9. Birthplace Blair Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Stones
13. Birthplace Blair, Va

MOTHER
14. Maiden Name Sallie Thompson
15. Birthplace Blair Va

16 (a) Informant Robert Johnson
(b) Address 1629 Jefferson St

17 (a) Burial
(Burial, cremation, removal)
(b) Date thereof Sept. 30 1948
(c) Cemetery or crematory Thompson Cemetery
Location Blair Va

18 (a) Funeral director Robert E. Williams
(b) Address 1545 McElderry

19 (a) SEP 28 1948
(Date rec'd by registrar)
(b) Huntington Nelligan, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at 2.48 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C. V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury At M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D.
Medical Examiner
Date signed September 27, 1948

VS 151

667175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Estelle Gill

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James W. Gill
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 17, 1880

8. AGE: Years 68 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Andrew Paul
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Margaret Briarton
15. Birthplace Baltimore, Md.

16 (a) Informant James W. Gill
(b) Address 2226 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick J. Cole
(b) Address 1200 W. Lombard St.

19 (a) Date received by local registrar 9-28-1948 (b) Signature and address of local registrar Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Sept 27 1948.
and that I last saw her alive on Sept 26 1948.

Immediate cause of death: Cerebrovascular hemorrhage

Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thurlington Williams, M.D.
Address 57 S. Fulton Ave. Date signed 9-27-48.

VS 153

G67176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. G67176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed or divorced: Separated

6 (b) Name of husband or wife

6 (c) If single, the age of years

7. Birth date of deceased (mo., day, yr.): 2-2-1896

8. AGE: Years 52 | Months 49 | Days | If less than one day hr. min.

9. Birthplace: S.C. (Town, county and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: Ben Williams

FATHER 13. Birthplace: S.C.

MOTHER 14. Maiden Name: Ann ?

MOTHER 15. Birthplace: S.C.

16 (a) Informant: Leroy Williams

(b) Address: 659-77 S. Richmond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep 28 1948

(c) Cemetery or crematory: Mt. Calvary

Location: A. Halstead

18 (a) Funeral director: 918 Druid Hill

(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, at 7:45 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulm. congestion & edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Emil H. Beyer M.D. Medical Examiner

Date signed 9/25/48

VS 151

G67177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G67177 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 S. Rose St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 S. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA Mc SHANE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Mc Shane | 6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lithuanian (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Not know
13. Birthplace: Lithuanian

MOTHER
14. Maiden Name: Not know
15. Birthplace: Lithuania

16 (a) Informant: Mrs. Helen Dempsey
(b) Address: 725 S. Rose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 29-48 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Dundalk Avenue

18 (a) Funeral director: John A. Grabianckas Jr.
(b) Address: 423 S. Paca St

19 (a) Received SEP 28 1948 (b) Buried or removed: Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 48 at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Sept 19 48.
and that I last saw he alive on Sept 24 19 48.

Immediate cause of death: Carcinoma of Stomach — Duration: 1 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Sept 1948

Major findings of operation: Inoperable Carcinoma Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Clarence W. LeDoux, M.D.
Address: 600 S. Eleventh St. Date signed: 9-29-48

VS 150

67178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paulina Progrebsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stasnilaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leo Danashuk
13. Birthplace Russian

MOTHER
14. Maiden Name Fedora
15. Birthplace Russian

16 (a) Informant Mrs. Anna Melnick
(b) Address 309 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Elkridge Md

18 (a) Funeral director John A. Grefbauckas
(b) Address 423 S. Paca St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Thursday for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Sept 27 1948. and that I last saw h alive on Sept 25 1948.

Immediate cause of death Marked Secondary Anemia

Due to SCIRRHOUS Carcinoma of Stomach

Due to Septic Mastitis

Other Conditions Myocardial Degeneration Duration Past year & Sept Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Last month
1 1/2 yr
2 yr
17 days

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: n/a
(a) Accident, suicide, or homicide
(b) Date of occurrence Sept 10 '48 at 7 a M
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no (Specify type of place)
(e) Means of injury Fell down steps.

23. Signature A. T. Ries

Address 24 S. Broadway Date signed Sept 28/48

VS 150

67179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 W. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Melvin H. OGLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: BESSIE K. OGLE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1902

8. AGE: Years	Months	Days	If less than one day
46	9	-	hr. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual Occupation: Boiler Maker

11. Industry or business: Baltimore & Ohio R.R.

FATHER
12. Name: George Ogle
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Roseller Houck
15. Birthplace: Maryland

16 (a) Informant: Mrs. Roseller M. Gorsey
(b) Address: 3206 Stanley Rd. Lansdowne

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 29/48 (month) (day)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE. . 17

19 (a) SEP 28 1948 (Date rec'd by registrar) by Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Ryan M.D.
Medical Examiner.

Date signed 9/29/48

67180

CERTIFICATE CORRECTED 9-1-56 ✓

BALTIMORE CITY HEALTH DEPARTMENT

ES-122621

CERTIFICATE OF DEATH 12B

667180 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. ~~672 Sarah Ann St.~~ 746 Bradley Av
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Magowan or Helen Mc Gowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	M

6 (b) Name of husband or wife Charles Magowan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 5?-25? ?

8. AGE: Years	Months	Days	If less than one day
50 ?	1 2	24	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Davis

13. Birthplace Va.

MOTHER

14. Maiden Name Anna?

15. Birthplace Va.

16 (a) Informant RECORDS- Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4- 19 48, at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 19 48 to 9-4 19 48.

and that I last saw her alive on 9-4 19 48.

Immediate cause of death Miliary Tuberculosis — Duration 6 mo.

Due to — Duration

Due to — Duration

Other Conditions Arteriosclerotic Cardiovascular disease — Duration 2yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. Stutzman

Address Balto City Hosp. Date signed 9-16-48 M. D.

VS 150

67181

J1- 13419

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93 D

G67181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Eutah Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Clarence Luther Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Alice P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1856

8. AGE: Years	Months	Days	If less than one day
91	11	25	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Luther Clark
13. Birthplace Iowa

MOTHER
14. Maiden Name Sarah Osborne
15. Birthplace N. Y.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1948, at 11.40 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Jan. 27, 1936, to Sept. 4 1948, and that I last saw h im alive on Sept. 4 1948.

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to

Due to

Other Conditions Arteriosclerosis Cardio-vascular Disease (Include pregnancy within 3 months of death) — years

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinton, M. D.
Address Balto City Hosp Date signed Sept 28 48

VS 150

107

82 JL -- 120731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

✓ 667182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John R. Saunders
13. Birthplace Md.

MOTHER
14. Maiden Name Cornelia B. Cherry
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health
18 (a) Funeral director
(b) Address
19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 4PM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1948 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death CVA — Duration 8 hrs

Due to Gen. A.S. — Duration 3 yrs

Due to — Duration

Other Conditions Malignant retro-peritoneal tumor - recurrent (Include pregnancy within 3 months of death) — Duration 1 yr

Date of operation 5/14/45

Major findings of operation: retro peritoneal tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosp. Date signed 9/28/48

VS 153

83a

7183

JL - 64178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

667183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Cloney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15. 1865

8. AGE: Years	Months	Days	If less than one day
83	-	16	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry
13. Birthplace Md.

MOTHER
14. Maiden Name Hester ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health
18 (a) Funeral director
(b) Address
19 (a) SEP 22 1948 (b) Huntington, Indiana, M.E.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1948, at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1948 to Aug. 31 1948. and that I last saw him alive on Aug. 31 1948.

Immediate cause of death: Bronchopneumonia, bilat
Due to: Arteriosclerosis, generalized
Other Conditions
(Include pregnancy within 3 months of death)
Duration: 3 days

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wallace H. Hughes M.D.
Address Balto City Hosp Date signed 8 Sept 48.

VS 150

184

ES- 100778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

Registered No. 667184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Orr

3 (b) If veteran, name war

3 (c) Social Security Account No. 535-05-4944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1903 Sept. 14, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	11	24		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Orr
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

15 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 48 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 19 46 to 8-28 19 48 and that I last saw h im alive on 8-28 19 48

Immediate cause of death: Bronchopneumonia, bilat — Duration: 3 days

Due to Cerebral Vascular Accident

Due to Arteriosclerosis, generalized.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kinlaw, Jr. M D
Address Balto City Hosp Date signed 9 Sep 48

VS 159

7185 JL -122275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 McKim St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March ? ?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75 ?				

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Strong Brooks
13. Birthplace S. C.

MOTHER
14. Maiden Name Frances Moffitt
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1948, 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1948 to Aug. 31 1948, and that I last saw him alive on Aug. 31 1948.

Immediate cause of death: PULMONARY TUBERCULOSIS ? — Duration: 2 MOS ?

Due to

Due to

Other Conditions CARDIAC FAILURE. SENILITY (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP Date signed 9-8-48

VS 150

185 90 39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

State Anatomical ✓ 55E

Registered No. 057186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Freeman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-8-88

8. AGE: Years	Months	Days	If less than one day
60	2	/	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Laurent Jordan
13 Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location

University Medical School SEP 21 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 3 P.M. 66

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1948 to Sept. 9 1948 and that I last saw h alive on 19

Immediate cause of death Carcinomatosis — Duration

Due to /

Due to

Other Conditions Atelectasis of Left Lower Lobe
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Sherman Wellington M.D.
Address Johns Hopkins Hosp. Date signed 9/10/48

VS 13C

667187 C-48-1942 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667187

CERTIFICATE OF DEATH

159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ of Md Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1264 Jones St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Eitel
3 (b) If veteran, name war — Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-48

8. AGE: Years	Months	Days	If less than one day
		3/24	5 hr. 13 min.

9. Birthplace Univ. of Md Hosp (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name George Eitel
	13. Birthplace Balto Md.
MOTHER	14. Maiden Name Virgie E. Hurst
	15. Birthplace Balto Md.

16 (a) Informant Mother - Virgie Eitel
(b) Address 1264 Jones St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 17 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 28 1948 (Date received by registrar) (b) Registrar

VS 150 For City Dispatch

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1948 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-14 1948 and that I last saw h[illegible] alive on 9-13 1948.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Raboen M. D.
Address University Hosp Date signed 9-14-48

667188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 667188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 St. Paul St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or ~~town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 St. Paul St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME FLORENCE E GROVE

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed,~~ or divorced.
F	W	DIVORCED

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) OCT. 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	1	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business —

FATHER
12. Name Joseph TRUMPOWER
13. Birthplace MD.

MOTHER
14. Maiden Name Mills
15. Birthplace Unknown

16 (c) Informant Miss Nelly M. Grove
(b) Address 24 W. 12th St N.Y. N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown

18 (a) Funeral director Wm S. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) 9-28 1948 (Signature of registrar) (b) Remington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 28 1948. to Sept 27 1948. and that I last saw h er alive on Sept 17 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions: Hepatitis recovering. (Include pregnancy within 3 months of death)	July 28-48

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M.D.
Address 1002 E. 23rd St Date signed Sept 28 48

130

G67189

148937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

309

G67189
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Eden, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hyde.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Absalom Hyde
6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr): 2-28-73

8. AGE: Years: 75 | Months: 6 | Days: 27 | If less than one day: hr. min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: William Bragg
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Caroline Carson
15. Birthplace: N. C.

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-1948. to 9-25-1948. and that I last saw her alive on 9-25-1948.

Immediate cause of death: Cardiac failure - acute - right sided & acute pulmonary edema — Duration: 6 hrs.
Due to: Arteriosclerotic cardiovascular disease
Due to: Generalized arteriosclerosis
Other Conditions: Pernicious anemia - Rx Cirrhosis (Banti's), Syphilis - latent Rx
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: — None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: O. Jackson, M.D.
Address: The Johns Hopkins Hosp. Date signed: 9/26/48

92D

VS 150

667190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 667190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3200 Wisteria Avenue
(c) Hospital or Institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Wisteria Avenue (If rural give location)
(e) Citizen of foreign country? ***** (Yes or No) If yes, name country *********

3 (a) FULL NAME Isaac A. Scopinich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence E. Stewart
6 (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr) June 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	22	** hr. ** min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business

FATHER
12. Name M. Antonio Scopinich
13. Birthplace Austria

MOTHER
14. Maiden Name Lucetta M. Cooper
15. Birthplace Bermuda

16 (a) Informant Mrs. Florence E. Scopinich
(b) Address 3200 Wisteria Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. C. Meads and Son
(b) Address 805 N. Calvert Street

19 Filed JUL 29 1948 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1948, to 7-27 1948, and that I last saw him alive on 7-27 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael Campbell MD
Address 5406 Belair Rd Date signed 7-28-48

67191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G67191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Scott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ba ltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CONRAD RAU

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-1873

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Nov. 28, 1873

8. AGE: Years 74 | Months 10 | Days - | If less than one day: hr. min.

9. Birthplace Ba ltimore, Md. (Town, county, and state)

10. Usual Occupation Butcher, Retired

11. Industry or business

FATHER
12. Name John Rau
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Schluderberg
15. Birthplace Germany

16 (a) Informant Margaret J. Rau
(b) Address 717 Scott St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Salem
Location Wilmington, Del

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948 19 . at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 19 48 to 9/28 1948.
and that I last saw him alive on 9/28 19 48.

Immediate cause of death: Acute Cardiac Collapse — Duration: 1da

Due to Carcinoma of Stomach C metastases — Duration: mos.

Due to Cardiovascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph G Lancaster M. D.
Address 6 Huntington Road Date signed 9/28/48

VS 150

192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Huntingdon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLOYD ARVILLE AUSTIN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-1458

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1904

8. AGE: Years 43 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Shenandoah, Va.
(Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Bethlehem Steel Co

FATHER
12. Name John Edward Austin
13. Birthplace Page Co., Va.

MOTHER
14. Maiden Name Mary J. Pence
15. Birthplace Page Co., Va.

16 (a) Informant Margaret Austin
(b) Address 3101 Puttey Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial
Location Dorsey, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 29 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 6 39/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939, to Sept 28, 1948, and that I last saw h[illegible] alive on Sept 27 1948.

Immediate cause of death: Cerebral thrombosis — Duration:

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack L. Berger, M.D.
Address 50 E. North Ave Date signed 9-28-48

VS 150

87193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

K 67193 Registered No.

Please write clearly and legibly. Use black ink or typewriter.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND + RAYNER AVES
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years 77 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Irvin Frenkil
(b) Address 3208 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philz Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 29 1948 (Date received by registrar) (b) Lillington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/48 1948 at 3:10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/27 1948 to 9/28 1948, and that I last saw her alive on 9/28 1948.

Immediate cause of death	Duration
Cerebral Hemmorrhage	
Due to Arteriosclerotic Hypertensive Heart Disease	
Due to Generalized	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Jedwab

Address West Balt. 21 Date signed 9/28/48

VS 150

67194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G67194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lewndale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Faunie

15. Birthplace Russia

16 (a) Informant Isaac Miller

(b) Address 2225 No Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herzog Mem

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2110 Eutaw Place

19 (a) (Date rec'd by registrar) SEP 29 1948 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948, at 4:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948, to 9-28 1948, and that I last saw her alive on 9-28 1948.

Immediate cause of death Pap Carcinoma of bowel with liver metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Ecker M. D.

Address Sinai Hosp. Date signed 9-28-48

VS 150

67195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 667195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 DIVISION STREET
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) WIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY EILEEN HOBBY Hobby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COLORED	MARRIED

6 (b) Name of husband or wife JOSHUA HOBBY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 28th, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	-	-		

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name CHARLES MARTIN
13. Birthplace Howard Co, Md.

MOTHER
14. Maiden Name CARRIE WATTS
15. Birthplace MONTGOMERY CO., MD.

16 (a) Informant HUSBAND NEAREST + DAUGHTER
(b) Address 1705 HARLEM AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 SEP 29 1948 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 26 1948 to Sept 28 1948 and that I last saw HER alive on Sept 28th 1948.

Immediate cause of death: RETROPERITONEAL HEMORRHAGE — Duration: 2 hrs.

Due to ONSET UNDETERMINED

Due to

Other Conditions DIABETES MELLITUS — UNKNOWN

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald
Address 8444 Carly Date signed 9/29/48

VS 150

103

667196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

667196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 577 Laurens st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 577 Laurens st. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Florence Millard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Louis Millard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1866

8. AGE: Years 82 | Months 7 | Days 6 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER: 12. Name not known
13. Birthplace —

MOTHER: 14. Maiden Name Eliza Davage
15. Birthplace Baltimore, Md.

16 (a) Informant Clarence Millard
(b) Address 577 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-48 (month) (day) (year)
(c) Cemetery or crematory Antrim Mem. Park
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 SEP 29 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.28.48 19 at 1:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.17.47 19 to 9.28.48 19, and that I last saw her alive on 9.26.48 19

Immediate cause of death cerebral hemorrhage — Duration Terminal

Due to cardio renal vascular disease — 1947

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James M Fair M. D.
Address 406 N. Carrollton Ave Date signed 9.28.48

VS 3

7197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Jenkintown (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Hillside Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bruckner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Emma Bruckner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-68

8. AGE: Years	Months	Days	If less than one day
80	0	5	hr min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Secretary, Credit man
11. Industry or business

FATHER
12. Name John Bruckner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dahnatz
15. Birthplace Germany

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd. Balto 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Montgomery Co. Pa.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. S. Weather Bur.) 105 E. Saratoga Avenue

19 (a) SEP 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16, 1948 to Sept. 28 1948, and that I last saw h l alive on Sept. 28 1948

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to Coronary sclerosis

Due to General arteriosclerosis

Other Conditions Psychosis with cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter O. Schwarz M.D.
Address The Seton Institute Date signed Sept. 28 1948

67198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 E. University Parkway (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mr. Gilbert Allen Jarman (GILBERT ALLEN JARMAN)

MEDICAL CERTIFICATION

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 213-01-3984

20. DATE OF DEATH Sept 28 1948, at 7 50 P M

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1948 to 9-28 1948, and that I last saw h/ alive on 9-28 1948

6 (b) Name of husband or wife: Marion Jones Jarman
6 (c) If alive, give age: 56 years

Immediate cause of death Pneumonia, Left Lower Lobe — **Duration**

7. Birth date of deceased (mo., day, yr.) Nov-15-1890

8. AGE: Years 57 | Months 10 | Days 13 | If less than one day: hr. min.

Due to Congestive Failure

9. Birthplace Kent Co. Md. (Town, county, and state)

Due to Hypertensive Cardiovascular Disease

10. Usual Occupation: Owner Jarman Motors
11. Industry or business: (Automobiles)

Other Conditions Saccular Aneurism

(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically

FATHER
12. Name: G. Allen Jarman
13. Birthplace: Kent Co. Md.

MOTHER
14. Maiden Name: Mary Emma McWhorter
15. Birthplace: Riverton, N. J.

Date of operation

Major findings of operation:

of autopsy: yes above

16 (a) Informant: Mrs. J. Dorsey
(b) Address: Mrs. G. A. Jarman 224 E. Univ. Pkwy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify)
(e) Means of injury

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director: Stewart Mortuary Co.
(b) Address: 1018 W. North Ave.

23. Signature: J. Frank Supplee, III
Address: Union Memorial Hosp. Date signed: Sept 28, 1948

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 152

67199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67199

BS-123217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Madison Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1911

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37	7	10		

9. Birthplace Centerville, Maryland.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles Brooks.
13. Birthplace Centerville, Maryland.

MOTHER
14. Maiden Name Lottie Johnson
15. Birthplace Centerville, Maryland.

16 (a) Informant RECORDS. BALTO CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 2, (month) (day) (year) 1948

(c) Cemetery or crematory Birdsville Cemetery
Location Centerville, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Sept 29 1948 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 19 48 at 5:30 M A

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23- 19 48 to 9-28 19 48, and that I last saw her alive on 9-28 19 48.

Immediate cause of death Probable malignant hypertension — Duration 2 wks.

Due to Subacute and acute glomerulonephritis — 4 years

Due to

Other Conditions Pulmonary edema — 3 hr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Probable glomerulonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 19 48 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Shutzman
Address Balto. City Hosp. Date signed 9-28-48

VS 159

667200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

667200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Rock Rose Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Thaler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 13 1864

8. AGE: Years 84 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jonny Thaler

13. Birthplace Germany

MOTHER 14. Maiden Name Jo Hoffman

15 Birthplace Germany

16 (a) Informant Mrs Maria Orell

(b) Address 2813 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director J. S. Harrison

(b) Address 3001 Pinkney Ave

19 (a) SEP 28 1948 (Date received by local registrar) (b) Huntington Williams M.D. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948 to 9-27 1948, and that I last saw her alive on 9-26 1948.

Immediate cause of death Gastro-intestinal Hemorrhage — Duration 5 days

Due to Arteria Sclerosis

Due to Cardio Vascular disease

Other Conditions N.P.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: c

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ira E Whitehill

Address 220 E. Monument Date signed 9/29/48

VS 150

X

67201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 4[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 Ballou Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Ballou Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Companion

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 297-10-7034

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Willa H.
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1903

8. AGE: Years 44 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace Charleroi Penna. (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

FATHER
12. Name Oscar Companion
13. Birthplace Belg.

MOTHER
14. Maiden Name Mary Glancy
15. Birthplace Soc.

16 (a) Informant Willa H. Companion
(b) Address 221 Ballou Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 - Belair Rd

18 (a) Funeral director Doppel Bros
(b) Address 1800 E. Lombard St

19 SEP 29 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1948 to Sept 28 1948, and that I last saw h[illegible] alive on Sept 28 1948.

Immediate cause of death	Duration
carcinomatosis	
Due to Cancer of rectum operated April 1945	
Due to	
Other Conditions Ca of Brain Growth removed Cerebrum (Include pregnancy within 3 months of death)	

Date of operation Aug 4/45

Major findings of operation: Carcinoma of rectum + Brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address 722 N. Kenwood Ave Date signed Sept 29/48

7202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 3a

Registered No. 667202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Florence Darden

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Hiram Lester Darden
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 1st, 1891

8. AGE: Years	Months	Days	If less than one day
57	2	25	########## min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mollie ?
15. Birthplace Virginia

16 (a) Informant Mr. Hiram Lester Darden (Husband)
(b) Address 1432 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 48 to Sept 26 19 48, and that I last saw h alive on 24 Sept 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 hr
Due to: Essential hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 714 E. Preston Date signed 24 Sept

V S 150

X

7203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4202 Elsrode Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Elsrode Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P.H. Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Minnie T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1875

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Minnie Schaefer
(b) Address 4202 Elsrode Ave

17 (a) Burial (b) Date thereof 9-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore

18 (a) Funeral director Lenard J. Luck
(b) Address 5305 Harford Rd.

19 (a) SEP 29 1948 (b) Clinton Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept. 1948 at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 27 Sept 48

VS 151

67204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

✓ 667204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Albemarle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Albemarle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Lyons

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife xxx James Lyons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 [illegible]7

8. AGE: Years	Months	Days	If less than 1 day
71 70	3	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Duffy
13. Birthplace England

MOTHER
14. Maiden Name Mary O'Brien
15. Birthplace England

16 (a) Informant Mrs. Margaret Cherigo
(b) Address 312 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. [illegible]st/48 (month) (day) (year)
(c) Cemetery or xxxxxx Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

SEP 29 1948 (Date rec'd by registrar)
(b) [illegible]ington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Sept. 28 1948, and that I last saw her alive on Sept. 28 1948.

Immediate cause of death: Pulmonary Edema — Duration: 1 day
Due to: Left ventricular cardiac insufficiency — Duration: 7
Due to: Senile Anemia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M.D.
Address 1732 N. Broadway Date signed 3/28/48

X

67205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G67205

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Albert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Ida
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 5-13-81

8. AGE: Years	Months	Days	If less than one day
67	4	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Sylvester Albert
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ? Blume
15. Birthplace Germany ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson St.

19 SEP 29 1948 (Date received by registrar) Huntington W. Disease Unit

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948, at 7 35A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1946 to 9/28 1946 and that I last saw h alive on 9/28 1946

Immediate cause of death Pulm. + Card. embolism — Duration, 10 min

Due to A. disc thrombosis — 10 days

Due to P.O. stroke

Other Conditions Benign Prost Hypert. Diabetes Mellitus (Include pregnancy within 3 months of death)

Date of operation 9-19-48

Major findings of operation B.P.H. & Diabetic Gangrene.

of autopsy: Lytton, H. Hobbs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Willard C. Brinton M. D.
Address Johns Hopkins Hosp Date signed 2 Oct 48

VS 150

667206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667206 Registered No. 926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 N Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Coleman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1903

8. AGE: Years	Months	Days	If less than one day
45	-	26	hr. min.

9. Birthplace Laurens S. C. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name	Clayton Coleman
FATHER 13. Birthplace	Laurens S. C.
MOTHER 14. Maiden Name	Isabel Burnside
MOTHER 15 Birthplace	Laurens S. C.

16 (a) Informant Osa Coleman
(b) Address 2600 McCulloh St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Mrs. Katie A. Williams
(b) Address 322 N. Schroeder St.
Sep 29 1948 (Date rec'd by registrar) (b) Registrar
Huntington-Williams, Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948 at 6:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948 to Sept. 27 1948, and that I last saw h[illegible] alive on Sept. 27 1948.

Immediate cause of death [illegible]

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 9/28/48

VS 150

G67207 ✓ G67207

GM. 123185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734½ W. Saratoga ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anderson Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 25- 1874

8. AGE: Years	Months	Days	If less than one day
73	8	29	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Esaw Harris (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Ellen ?
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 24- 1948 at 9.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1948 to 9- 24- 1948 and that I last saw him alive on 9- 24 - 48

Immediate cause of death Malnutrition — Duration months

Due to Carcinoma of the stomach — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of stomach

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J. Eric M.D.
Address 4940 Eastern Ave Date signed 9/28/48

G67208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G67208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 W. 24th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 121 W. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia P. Sumwalt

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1860

8. AGE: Years 87 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Sumwalt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ann --
15. Birthplace Pa.

16 (a) Informant Mrs. Florence E. Sumwalt
(b) Address 4307 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) SEP 29 1948 (Date received by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept. 1948, at 3:27 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of R. Breast

Due to

Other Conditions Arteriosclerotic Cardio-Vascular Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner.
Date signed 27 Sept. 48.

G67209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67209

Registered No. 716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2437 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAPT. JOHN PATRICK McSHANE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sue Dennis McShane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1880

8. AGE: Years: 68 Months: 7 Days: 15 If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Balto. City Fire Department

FATHER
12. Name: John T. McShane
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary J. Afroux
15 Birthplace: Md.

16 (a) Informant: Mrs. Sue Dennis McShane
(b) Address: 2437 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Sep 28 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Sept 27 1948 and that I last saw him alive on Sept 27 1948

Immediate cause of death: Cardiac failure — Duration:

Due to Carcinoma of Prostate & metastasis to Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti
Address 1729 W. Lombard St Date signed 9/28/48 M. D.

Albert Scagnetti ×

667210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667210 Registered No. 1-21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Tremont St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sophia Bullock
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Fe. | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased: mo., day, yr 7-28-80
8. AGE: Years 68 | Months 1 | Days 25 | If less than one day: hr. min. 24
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Stansbury
13. Birthplace Md

MOTHER
14. Maiden Name Annie Trust
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address Provident Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto, Md.

18 (a) Funeral director Harold L Brownston
(b) Address 1000 W Lanvale St

19 (a) 9 29 1948 (b) (Rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-48 (Month) (day) (year) 1:45 p.m. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-23 1948 to 9-25 1948 and that I last saw h alive on 9-25 1948

Immediate cause of death Coronary occlusion
Duration

Due to Cardiac embarrassment

Due to Generalized arteriosclerosis

Other Conditions Hypertension
(Antecedent causes)
(Unstable pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 9-27-48

VS 150

95c

Cal 2 667211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667211 Registered No. 115c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 423 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Morris Tatum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-6-84

8. AGE: Years	Months	Days	If less than one day
26	4	20	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name John Tatum
13. Birthplace Va.

MOTHER 14. Maiden Name Susie Farham
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29/48 (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg Va.

18 (a) Funeral director Mr. Robert G. Elliott Esq
(b) Address 1129 N. Caroline St

19 (a) SEP 29 1948 (Date rec'd by registrar) Livingston Williams Registrar

MEDICAL CERTIFICATION

05 A

20. DATE OF DEATH 9-28 1948 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 9-28 1948, and that I last saw h[illegible] alive on 9-28 1948.

Immediate cause of death: Polyneuritis +/or encephalitis — Duration
Due to: ? diphtheria
Due to: ? infectious (post) encephalitis
Other Conditions: Palato-pharyngeal paralysis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work)
(e) Means of injury

23. Signature William W. Winternitz M. D.
Address Johns Hopkins Hospital 9-28-48

VS 150

876

G67212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G67212

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 617 N. Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena M. Clark,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Robert A. Clark
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1868

8. AGE: Years	Months	Days	If less than one day
79	10	17	hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name William E. Abell,
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Jane Russell,
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Miss Anna Mae Clark,
(b) Address 4948 Denmore Ave.,

17 (a) burial (b) Date thereof 9/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) 1948 (b) Washington Williams, Registrar
29 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46 to 9/27 19 48 and that I last saw h[er] alive on 9/27 19 48

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerosis

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 week
3 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry F. Kane M. D.
Address 2607 E. Preston St. Date signed

V S 150

667213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

667213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 W Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town City (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 W Biddle St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Roaf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Willie Roaf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Balto City (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Beckett
13. Birthplace Va

MOTHER
14. Maiden Name Elnora Johnson
15. Birthplace Va

16 (a) Informant Willie Roaf
(b) Address 523 W. Biddle St

17 (a) Burial (b) Date thereof 10/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Co.

18 (a) Funeral director Wm J Jackson
(b) Address 916 Penna Ave

19 (a) SEP 29 1948 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/48 19 , at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/48 to 9/24/48 and that I last saw h[illegible] alive on 9/24/48

Immediate cause of death	Duration
Pulmonary Embolism	Several weeks or more
Due to Pregnancy	
Due to	
Other Conditions Contributory — Breech Birth	

(Include pregnancy within three months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Barnard M. D.
Address 526 N. Carey Date signed 9/29/48

667214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667214
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Bavard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-8-68

8. AGE: Years 80 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Oliver
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1510 Bloomsbury Ave Huntington Md. Baltimore, Md.

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

VS 150 Released to Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 10 20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1948, to 9/27 1948 and that I last saw him alive on 9/27 1948

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertensive arteriosclerotic cardio
Due to: vascular disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William W. Winternitz, M.D.
Address Johns Hopkins Hospital Date signed 9-27-48

G67215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G67215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 496 Brunswick St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 496 Brunswick St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Weddle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife John W. Weddle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	17	hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Ephriam W. Ridge
13. Birthplace MD.

MOTHER
14. Maiden Name MARTHA EVA DOMER
15. Birthplace MD

16 (a) Informant MRS. ANNABELLE JACOBS
(b) Address 496 BRUNSWICK ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-1948 (month) (day) (year)
(c) Cemetery or crematory Lewistown M.E.
Location Lewistown Md.

18 (a) Funeral director M. R. Ecleston & Son
(b) Address Frederick, Md.

19 (a) [illegible] rec'd by registrar] (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Sept 27 1948, and that I last saw her alive on Sept 27 1948.

Immediate cause of death — Duration
Arteriosclerotic Cardio-vascular Disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 107 E. Main St. Date signed 29 Sept M. D.

Lexington Medical, Inc.

G67216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. G67216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 27 days
(e) Length of stay in Baltimore (yrs., mos., or days): 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Bethesda (If outside city or town limits, write RURAL and give town)
(d) Street No.: 6608 Clarden Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: NEVA LENORE ELLIS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): March 29, 1906

8. AGE: Years	Months	Days	If less than one day
42	6	-	hr. min.

9. Birthplace: Demorest, Ga. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: John E. Ellis
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Neva Marshall
15. Birthplace: Ga.

16 (a) Informan: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29 48 (month) (day) (year)
(c) Cemetery or crematory: Reynolds Ga
Location: Georgia

18 (a) Funeral director: Williams Cook Inc
(b) Address: 1217 St Paul St

SEP 29 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1948 to Sept. 29 1948, and that I last saw her alive on Sept. 29 1948.

Immediate cause of death	Duration
Metastatic carcinoma (primary site, left breast) involving liver, lung,	8 yrs.
Due to adrenals, bone	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 1941
Major findings of operation: Mastectomy, radical , left
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 9/29/48

G67217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G67217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 N. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE EDMUND ADAMS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Cora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871

8. AGE: Years 77 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrician's Helper Retired

11. Industry or business

FATHER
12. Name Edmund Adams
13. Birthplace Bermuda

MOTHER
14. Maiden Name Martha E. Grove
15. Birthplace Maryland

16 (a) Informant Sophia Yeager
(b) Address 1401 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

(Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948 19 , at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 19 48 to Sept 29 19 48, and that I last saw h[illegible] alive on Sept 28 19 49.

Immediate cause of death	Duration
Coronary Embolism	1 hr
Medical Regurgitation	1 yr
Due to Chronic Nephritis	1 yr
Hypertension	1 yr
Due to Chronic Interstitial Nephritis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] Stevens M. D.

Address [illegible] Date signed 9/29/48

9 29 1948

X

667218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667218

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 954 Forrest Street
(c) Hospital or institution: Maryland Penitentiary Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 954 Forrest St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lola Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1904

8. AGE: Years 44 | Months 3 | Days 1 | If less than one day: hr. min.

9. Birthplace Braddock, Pennsylvania (Town, county, and state)

10. Usual Occupation Skilled Laborer

11. Industry or business

FATHER
12. Name Walter Wilson (deceased)
13. Birthplace East Indies

MOTHER
14. Maiden Name Lilly Fulton (deceased)
15. Birthplace Hayden, Virginia

16 (a) Informant Deceased
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) [illegible] for [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Bronchopneumonia — Duration

Due to Etiology undetermined

Due to

Other Conditions: 1. Possible Tuberculosis 2. Hypertensive Cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. D. Hollyis, M.D.
Address Maryland Penitentiary Date signed 9/9/48.

107

VS 150

67219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G67219
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Eisland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1948 at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Specify
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed

VS 151

667220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. 667220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224
(c) Hospital or institution: Balt. City Hosp. Bad. Asy.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48			hr min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (c) SEP 23 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 1948, at 2.10 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 22

(a) Date of injury 9-11-48 at approx. 1.30 p. M.
(b) Where did injury occur? Pier #16, Balto. Md. Light St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place while at work? yes
(d) Means of injury Found drowned

23. Signature M.D.
Medical Examiner.
Date signed 12 Sept 48

VS 151

G67-21

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67-21 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hr. 15min.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Dorn St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles WICKS

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
27			..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) **(b) Date thereof** ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director .....
(b) Address .....

19 SEP 29 1948 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Edema of brain
Scarring of heart.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667222 (Registered No.) 667222

GM. 123170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Fusting Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Axer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	D

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
81 ?			hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Axer
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna E. Heck
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-48 (month) (day) (year)
(c) Cemetery or crematory Rock Spring
Location Forest Hill Md

18 (a) Funeral director Martin Ekunz
(b) Address Jarrettsville Md

SEP 29 1948 (Date received by registrar) (b) Interment, Removal, or Cremation

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 29- 1948, at 1.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 22- 1948 to 9- 29- 1948 and that I last saw him alive on 9- 29 - 1948.

Immediate cause of death: Bronchopneumonia — Duration: 5 days.

Due to

Due to Arteriosclerotic heart disease & failure ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H Marcus M.D.
Address Balto City Hosp. Date signed 9-29-48

667223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 460

Registered No. 667223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4443 Dorchester Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora E. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Edmund H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1901

8. AGE: Years	Months	Days	If less than one day
47	6	27	hr. min.

9. Birthplace Texas - Md. (Town, county, and state)
10. Usual Occupation Asst Clerk
11. Industry or business American Stores Co

MOTHER / FATHER
12. Name Unknown Thompson
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace " "

16 (a) Informant Edmund H Williams
(b) Address 4443 Dunmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 1 48 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Sullivan Cook Inc
(b) Address 1212 St Paul St.

19 SEP 30 1948 Hunter Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1948, to 9/28 1948, and that I last saw her alive on 9/26/48 19

Immediate cause of death: Pancreatic fistula

Due to Ca of Head of pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of Head of Pancreas

of autopsy: Pancreatic fistula

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee N. Kaahn M. D.
Address 3206 N. Hilton Date signed 9/29/48

150

667224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667224 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a a
(c) City or town Churchton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Blunt "a"

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 9-19-1948

8. AGE: Years | Months | Days: 1 | If less than one day: 5 hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER 12. Name Donald Gray ?
13. Birthplace

MOTHER 14. Maiden Name Mary Blunt
15. Birthplace ?

16 (a) Informant: Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 SEP 30 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 00

20. DATE OF DEATH Sept. 19 1948 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-1948 to 9-19-1948 and that I last saw h[illegible] alive on 9-19-1948.

Immediate cause of death | **Duration**

atelectasis

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature a. c. Haring M.D.
Address Johns Hopkins Hosp. Date signed 21 Sept 48

VS 150

667225 Rev 48-20926 667225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give Town)
(d) Street No. 1003 Linden Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Hopkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-48

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hopkins
13. Birthplace

MOTHER 14. Maiden Name Rita ?
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1948, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948, to 9/26 1948 and that I last saw her alive on 9/26 1948

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Harry

Date signed 9 27 48

VS 150

667226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 667226

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Harford

(c) City or town Belair

(If outside city or town limits, write RURAL and give town)

(d) Street No. RFD 2

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Dearborough Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/48

8. AGE: Years | Months 2 | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Merrel Dearborough

13. Birthplace 2

MOTHER 14. Maiden Name

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 30 1948 Huntington Williams, M.D.

(Date received by Registrar) (Address) (Date signed)

MEDICAL CERTIFICATION

30

20. DATE OF DEATH Sept. 27 1948 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1948 to 9/27 1948 and that I last saw h alive on 9/27 1948

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Paul Pupa M. D.

VS 150

667227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

667227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2240 Tacoma St. Westport
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore MD. Zone 30
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME SUE NEWKIRK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Paul Newkirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	4	10		

9. Birthplace Millville New Jersey
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

MOTHER / FATHER
12. Name Charles Syfer
13. Birthplace Millville New Jersey
14. Maiden Name Sarah Penn.
15. Birthplace Millville New Jersey

16 (a) Informant Mrs. Sara Mueller
(b) Address 2349 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Maryland

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 West North Ave.

19 SEP 30 [illegible] Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948 3:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-27 1948 to 9-28 1948 and that I last saw her alive on 9-28 1948

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	
Due to CORONARY THROMBOSIS	
Due to CORONARY SCLEROSIS	
Other Conditions GENERALIZED ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel V. Scalia
Address Co. Balto. Gen. Hospital Date signed 9-28-48

VS 150

67228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67228

164a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3940 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SOLLINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Olga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Liquor Store

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Russia

MOTHER 14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Olga Sollins

(b) Address 3940 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) SEP 30 [illegible] (Received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/48 19 .6 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions Marked Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/29/48 at 5:30 P. M.
(b) Where did injury occur? 506 Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Place of Business (While at work?) Yes
(d) Means of injury Hung self by Cord Hanger

23. Signature John R. Devine M.D.
Medical Examiner.

Date signed 9/30/48

VS 151

G67229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G67229 Registered No.

161c.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Fourth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin E. Shenton

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. ***** **

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1948

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace Lansdowne, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Calvin E. Shenton
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Bettie Margaret Barton
15. Birthplace Baltimore Maryland

16 (a) Informant Calvin E. Shenton
(b) Address 123 Fourth A ve. Balto. 27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, '48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A.A. County Maryland

18 (a) Funeral director F.B. Wippert & Son
(b) Address 1300 Eutaw Place, 17

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 881

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29. 1948, at 12:30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital icterus of newborn

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9/29/48

G67230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pauline Meyers
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 27th 1893

8. AGE: Years	Months	Days	If less than one day
54	11	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Printer.

FATHER
12. Name William Meyers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margarine Ehrline
15. Birthplace Baltimore

16 (a) Informant Pauline Meyers
(b) Address 721 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 or (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 3005 Orleans St.

19 (a) SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27- 1948, at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948, to 9-27 1948, and that I last saw him alive on 9-27 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp Date signed 9-28-48

VS 150

Please write the causes of death clearly and legibly.

67231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Richards

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 4th 87

8. AGE: Years 71 | Months 5 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Edw F. Richards
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Conroy
15. Birthplace Md

16 (a) Informant Mrs Mary McComas
(b) Address 1233 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 30 1948 (Date received by registrar) Huntington Williams, M.D. Registrar, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1948 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 1948, and that I last saw her alive on Sept 21 1948.

Immediate cause of death Coronary thrombosis

Due to Coronary sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd. Date signed 9-29-48

VS 150

G672232

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

Registered No. G672232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Chelsea Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Chelsea Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Byers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Elandt

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) December 5, 188?

8. AGE: Years	Months	Days	If less than one day
65	9	22	hr. min.

9. Birthplace Council Bluffs, Kansas (Town, county, and state)

10. Usual Occupation Railway mail clerk,

11. Industry or business retired four months

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary E. Byers
(b) Address 1911 Chelsea Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John C. Mitchell's Sons, Etc.
(b) Address 1905 Eutaw Place

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. M. H. Hammer, M.D. Medical Examiner.
Date signed 28 Sept. 48

VS 151

667233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

667233 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8-21 15 years
(e) Length of stay in Baltimore (yrs., mos., or days) 92 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Strother, Mrs Alice H

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	

6 (b) Name of husband or wife: Rev. Frank M. Strother deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 23-1856

8. AGE: Years	Months	Days	If less than one day: hr.	min.
92	7	6		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Dr John W Fletcher Hank
13. Birthplace Springfield Ohio

MOTHER
14. Maiden Name Annie M Keener
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Frances M Hazard Sister
(b) Address 700 W. 40th Street Balto

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 1-1948 (month) (day) (year)
(c) Cemetery or crematory Family Burying Ground
Location Mayfield Post Office

18 (a) Funeral director Gittings Fire
(b) Address 2330 N Charles St

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1948 at 12 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1933 to 9/29 1948 and that I last saw h[illegible] alive on 9/29 1948.

Immediate cause of death: Arteriosclerosis (Senility) — Duration 12 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Grafton Hergberger M. D.
Address 214 Medical Arts Bldg Date signed 9/30/48

VS 150

G67234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67234

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Fleetwood Rd
(c) Hospital or institution: Ashburton Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Fleetwood Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Stroney Geass

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1864

8. AGE: Years	Months	Days	If less than one day
83	9	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name	James A Geass
FATHER 13. Birthplace	Md
MOTHER 14. Maiden Name	Sarah V Geas
MOTHER 15. Birthplace	Md

16 (a) Informant Howard W Geass
(b) Address 734 Rockrose Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Bothum & Son
(b) Address 3224 N Charles St

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948; at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 29 1948, and that I last saw h-er alive on Sept 28 1948.

Immediate cause of death	Duration
(a) Bronchial Pneumonia	3 d
Due to (b) Cerebral Thrombosis	1 yr
Due to (c) Arteriosclerosis + Hypertension	1 yr
Other Conditions Chronic Interstitial Nephritis	1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fit Stevens M. D.
Address 2818 Harford Date signed 9 30 48

V S 150

82a

G67235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67235 Registered No.

1.69

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES N. RITTER

3 (b) If veteran, name war: W.W. II

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: MARY (Evelyn) Ritter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1915

8. AGE: Years 33 | Months 0 | Days 20 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Brakeman

11. Industry or business: Western Md. R.R.

FATHER
12. Name: George Ritter
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: (Unknown) MARY WHITEFORD
15. Birthplace: Unknown

16 (a) Informant: Mrs. Evelyn Ritter
(b) Address: 429 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 48 (month)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Philip Herwig & Sons
(b) Address: 2024 Orleans St.

SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948 at 6.40a M

21. I certify that I took charge of the remains described above, held an partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Evisceration of abdomen (Traumatic) Traumatic amputation of Rt. arm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-29-48 at approx 4.30 a. M.
(b) Where did injury occur? Port Covington, W.Md.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? Yes
(d) Means of injury Caught between r.r. cars & dragged

23. Signature Earl K. Ryder M.D. (Medical Examiner)
Date signed September 29, 1948

VS 15

667236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667236 ✓ Registered No. 122a

CERTIFICATION APPROVED BY: J. Huddleson M.D. M. D. CHIEF OR ASST. MEDICAL EXAMINER.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave.
(c) Hospital or institution St. Agnes Hosp. (D. O. A.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Allendale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULA MAY BURNS

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female
5. Color or race: white
6 (d) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Howard L. Burns, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1884

8. AGE: Years 63 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Walker
13. Birthplace Md.

MOTHER
14. Maiden Name K. Catherine Walling
15. Birthplace Md.

16 (a) Informant Mr. Howard L. Burns, Jr.
(b) Address 2504 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Registrar's signature) (b) Huntington Williams M.D. Registrar

SEP 30 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Sept 28 1948, and that I last saw h m alive on Sept 27 1948.

Immediate cause of death: Cerebral Embolism — Duration: 10 min.
Due to:
Due to: Arteriosclerosis — 2 yrs
Other Conditions: diabetes Mellitus. — 5 years
(Include pregnancy within 3 months of death)

Date of operation 9/6/48
Major findings of operation: ventral hernia lower abdomen
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Gareth Mortimer Jr Med M. D.
Address 2706 St Paul St. Date signed 9/29/48

6672237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 6672237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Ridgewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Harvey Snyder Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1868

8. AGE: Years	Months	Days	If less than one day
80	2	26	hr. min.

9. Birthplace Easton, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Muhl
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Ralph W. Martin
(b) Address 102 Ridgewood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1948 (Date rec'd by Reg.) Huntington Williams, M.D. (b) Address 20-1/2 York Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to Sept 27 1948. and that I last saw her alive on Sept 27. 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Huntington Williams, M.D.
Date signed 9-1-48

VS 150

6672238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6672238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge, Balto (21) (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Marion Bostwick Davis

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Clara Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1877

8. AGE: Years 71 | Months 8 | Days 1 | If less than one day: hr. min. 29

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation Retired Manufacturer

11. Industry or business

FATHER
12. Name Arthur Davis — dead
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Bostwick — dead
15. Birthplace Unknown

16 (a) Informant Mr. Marion B. Davis Jr.
(b) Address Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Elkridge Episc. Cem.
Location Eldridge, Md.

18 (a) Funeral director W. J. TICHER & SONS INC.
(b) Address North & Pa. Aves.

19 (a) SEP 30 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Sept 1945, at 11:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1945 to Sept 25 1945, and that I last saw h[im] alive on 25 Sept 1945.

Immediate cause of death Generalized abdominal carcinomatosis — Duration

Due to Retroperitoneal tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug. 11, 1945 & Sept. 5, 1945

Major findings of operation: Retroperitoneal tumor, & metastatic carcinoma of ileum

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Blanche P. Grant, M.D.
Address Union Memorial Hosp. Date signed 9/29/45

VS 150

667239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

667239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Avon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert FEHLEISEN

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of ~~husband~~ wife Emma Louise Fehleisen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-~~13~~-79

8. AGE: Years	Months	Days	If less than one day
69	5	14~~3~~	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Steamship Lines

FATHER
12. Name Louis Fehleisen
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Martin
15. Birthplace Germany

16 (a) Informant Mrs. Edna Wilbur
(b) Address 1700 W St. S.E. Wash, DC.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Parkwood
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICHER & SONS INC.
(b) Address North & Ra. Aves. Balto. 17, Md.

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Hunting-Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 September 1948, at 10~~55~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Sept 1948 to 28 Sept 1948 and that I last saw h~~im~~/~~er~~ alive on 28 Sept 1948.

Immediate cause of death	Duration
Carcinoma of Recto sigmoid with metastases to lymph nodes	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 21, 1948
Major findings of operation: same as above
of autopsy: same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. Frank Supplee III M. D.
Address Union Memorial Hosp Date signed Sept 25, 48

VS rso

67240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 67240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Harford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1211 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NANCY K. IGLEHART

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Dr. J. Howard Iglehart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1877

8. AGE: Years: 71 | Months: 0 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Sweet Chalybeate Spring, W. Va. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business:

FATHER
12. Name: Kinnirey
13. Birthplace:

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant:
(b) Address:

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/1/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 30 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948, at 1:00p M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-Nov 1945 to 28-Sept 1948 and that I last saw h[illegible] alive on 28-Sept 1948

Immediate cause of death: Coronary Thrombosis — **Duration:** 1 day

Due to: Arterio Sclerotic Cardio Vascular Disease — **Duration:** Nov-45

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Chas W. Edmunds M. D.
Address 2776 Fleetwood **Date signed** Sept 29 48

VS 150

Medical Examiner's case.

D.O.A.
G67241

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G67241

CERTIFICATE OF DEATH

1600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mayne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/48

8. AGE: Years	Months	Days	If less than one day
—	—	—	9 hr. 30 min.

9. Birthplace Halethorpe Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Mayne
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Engelke
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Pennsylvania
Location Harford Co Md

18 (a) Funeral director Edgar Markert
(b) Address Catonsville Md

19 SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 MEDICAL EXAMINERS CASE

MEDICAL CERTIFICATION

20. DATE OF DEATH Dead on Arrival Sept. 29 1948, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw h alive on 19 .

Immediate cause of death. Intracranial Hemorrhage
Prematurity

Due to

CERTIFICATION APPROVED BY
Due to Thomas J. Mackie, M.D.
For William H. Kammer, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. N. Lyons M. D.
Address Johns Hopkins Hospital 9-29-48

To be Approved by Medical Examiner
Released to Hospital

G67242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95-

Registered No. G67242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Sidney Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Sidney Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Benny

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1889

8. AGE: Years 59 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER 12. Name Geo. S. Benny
FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Mary Erganstein
MOTHER 15. Birthplace Md.

16 (a) Informant Mrs. Martha Benny
(b) Address 2205 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1/48 (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Jersey, Md

18 (a) Funeral director Henry H. Kritzler
(b) Address 4101 Edmondson Ave

SEP 29 1948 (b) Registrar Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948 at 7:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 - 1943, to Sept 28 1948, and that I last saw him alive on 9-28-1948.

Immediate cause of death Coronary thrombosis | Duration unknown

Due to

Due to

Other Conditions Coronary Thrombosis | 8 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Ruland M. D.
Address 2532 Edmondson Ave Date signed 9-29-48

VS 150

The accuracy, completeness, legibility, and promptness of physicians: please write the causes of death clearly and legibly.

667243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Cole St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Cole St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frances C. Reuwer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Godfred A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1880

8. AGE: Years 66 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Thomas Coop
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Godfred A. Reuwer
(b) Address 1708 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 '48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick DR

18 (a) Funeral director Henry A Wiltze
(b) Address 4101 Edmondson AVE
SEP 30 1948 (Date rec'd by Registrar) Lington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948 at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1948 to 9/29 1948
and that I last saw h[illegible] alive on 9/29 1948.

Immediate cause of death: Duration
Cerebral arterio sclerotic heart disease 3 yrs
Due to
Due to Hypertension
Other Conditions Cerebral Hemorrhage 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 1030 Wilkens Date signed 9/30/48

Cert X

VS 150

Physicians: please write the causes of death clearly and legibly. The [illegible] Physicians: please write the causes of death clearly and legibly. The [illegible] carefully supplied. The [illegible] carefully supplied.

67244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 488

Registered No. 67244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 South Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 South Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Kleiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Adolph Kleiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 2, 1867

8. AGE: Years	Months	Days	If less than one day
80	9	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Frances (Unknown)
15. Birthplace

16 (a) Informant Marie Schifferer
(b) Address 622 S. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 South Wolfe St. Balto. Md.

1948 SEP 30 (Date rec'd by registrar) 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 27, 1948 19 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 48 to Sept 27 19 48
and that I last saw h alive on Sept 27 19 48

Immediate cause of death Carcinoma Uterus — Duration 4 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature A. J. McElwee M. D.
Address 3026 Eutaw Place Date signed Sept 27/48

VS 150

G67245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G67245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5610 Mattfeldt
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5610 Mattfeldt Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Lloyd Ensor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced** Widower

6 (b) Name of husband or wife Eleanor Ensor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28-1852

8. AGE: Years 96 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Retired 24 years

FATHER
12. Name George Ensor
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Lloyd
15. Birthplace Maryland

16 (a) Informant Miss Nellie V. Ensor
(b) Address 5610 Mattfeldt Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 1-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 30 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Aut & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. McGee M.D.
Medical Examiner.

Date signed Sept 29, 1948

VS 181

G67246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67246

Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Colorado Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Colorado Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Linton Stephens

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie E. Stephens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 17, 1856

8. AGE: Years	Months	Days	If less than one day, hr.	min.
92	2	12		

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired 25 years

FATHER
12. Name Joseph Stevens
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda ---
15. Birthplace Pennsylvania

16 (a) Informant A. L. Stephens
(b) Address 714 Colorado Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Baltimore Co., Maryland

18 (a) Funeral director Burge Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 30 19[illegible] (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948, at 1.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1948, to Sept 29 1948.
and that I last saw h[illegible] alive on Sept 29 1948

Immediate cause of death
Myocardial infarction
& Thrombosis pneumonia

Duration
10 days

Due to
Arteriosclerosis

2.

Due to
Cardiac disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Huntington Williams M.D.
Address 3429 Chestnut Ave. Date signed Sept 30 1948

VS 150

67247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 50

Registered No. 67247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha P. Germann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/4/1877.

8. AGE: Years	Months	Days	If less than one day
70	11	24	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Germann
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ada Elliott
15. Birthplace Virginia.

16 (a) Informant Hospital Records.
(b) Address St. Agnes Hospital.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 1 - 1948. (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery.
Location Alexandria - Va.

18 (a) Funeral director Charles J. Schwob.
(b) Address 3512 - Frederick Ave.

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1948, at 12:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/ 1948 to 9/25/ 1948, and that I last saw h-r alive on 9/25/ 1948

Immediate cause of death Cardio-Resp. failure - severe diabetes

Due to severe cardiac arrhythmia

Due to acute dilitation of stomach

Other Conditions Breast tumor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Vensel Jr. M.D.
Address St. Agnes Hospital Date signed 9/28/48

VS 150

61

G67248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67248
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Leeds Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Ebenwein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Dora A. Ebenwein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-19-1877

8. AGE: Years 71 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland-Baltimore
(Town, county and state)

10. Usual Occupation Wood Worker

11. Industry or business Pittsburgh Plate Glass

FATHER
12. Name August Ebenwein.
13. Birthplace Germany.

MOTHER
14. Maiden Name Louise Hondreigh.
15. Birthplace Germany.

16 (a) Informant Mr. August Ebenwein Jr.
(b) Address 438-N. Pulaski St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 2-'48. (month) (day) (year)

(c) Cemetery or crematory London Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick, Ave.

19 (a) SEP 30 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1948, to 9-29 1948, and that I last saw him alive on 9-29 1948.

Immediate cause of death CARDIO. RESPIRATORY FAILURE — Duration

Due to CEREBRAL ARTERIOSCLEROSIS
SECONDARY LUES

Due to HEPATIC CIRRHOSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ans. above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Shaw M.D.
Address St. Agnes Hosp. Date signed 9/29/48

667249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County *******
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country

3 (a) FULL NAME Colonel Archibald Francis Commiskey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Haile
6 (c) If alive, give age *** years

7. Birth date of deceased (mo., day, yr.) July 4, 1874

8. AGE: Years	Months	Days	If less than one day
74	2	24	** hr. *** min.

9. Birthplace Brooklyn, New York
(Town, county, and state)
10. Usual Occupation Retired Colonel
11. Industry or business U. S. Army

FATHER
12. Name Francis Wm. Commiskey
13. Birthplace New York, N. Y.

MOTHER
14. Maiden Name Margaret McCormick
15. Birthplace New York, N. Y.

16 (a) Informant Mrs. Margaret H. Commiskey
(b) Address 100 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Arlington
Location Virginia

18 (a) Funeral director H. W. Meares and Son
(b) Address 105 E. Calvert Street

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 11.15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to Sept. 28 1948.
and that I last saw h alive on Sept. 28 1948.

Immediate cause of death: Coronary occlusion — Duration: Re-cumbance

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Gerr M.D.
Address 1145 St. Paul St. Date signed 9/30/48

667250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. 667250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Presstman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Trueman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-1894

8. AGE: Years	Months	Days	If less than one day
54		27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Alfred Trueman
13. Birthplace [illegible] ?

MOTHER
14. Maiden Name Messy Ireland
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Law
(b) Address 102 Madison avenue

19 SEP 30 1948 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1948, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1948 to 9-28 1948; and that I last saw her alive on 9-28 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension (Essential)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Sherman Mellinkoff M.D.
Address Johns Hopkins Hosp. Date signed 9/29/48

VS 150

667251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T2a

Registered No. 667251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Lakewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas C. Lenhoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Julia C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	7	11	hr. min.

9. Birthplace Baltimore Co, Md. (Town, county, and state)
10. Usual Occupation Commission Merchant
11. Industry or business

FATHER
12. Name Adam Lenhoff
13. Birthplace France

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Julia C. Lenhoff
(b) Address 702 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) SEP 30 1948 (b) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 19 1948, to Sept. 27 1948, and that I last saw him alive on Sept. 27 1948.

Immediate cause of death: Cerebral apoplexy. — Duration: 9 days

Due to Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Leon C. Lenhoff M. D.
Address 701 N. Kenwood Ave. Date signed 9/29/48

495063 3672252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 3672252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Texas (b) County
(c) City or town Waco -
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Libby Janeka Tiesz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-20

8. AGE: Years 27 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Texas - (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

MOTHER / FATHER

12. Name Victor Janeka

13. Birthplace Texas -

14. Maiden Name Francis Machacek

15. Birthplace Texas

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)

(c) Cemetery or crematory PENELOPIE

Location TEXAS.

18 (a) Funeral director Jos. O. Nichol. Sons

(b) Address Waco Central Pl.

19 SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Sept 30 1948 and that I last saw h alive on Sept 30 1948

Immediate cause of death Embryonal blastoma of the ovary -

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation September 25, 1948

Major findings of operation: Widespread necrotic tissue in abdomen.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature John Waite Jr. M.D.

Address Johns Hopkins Hosp. Date signed Sept 30 1948

VS 150

G67253 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 67253

CERTIFICATE OF DEATH

9 3 D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 Walbrook Ave St. 15-16 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME ANNA M. MARCKS

If U. S. Veteran specify WAR .....

(a) Residence: No. 2824 Walbrook Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced (or) WIFE of Martin Marcks

6. DATE OF BIRTH (month, day, year) Aug. 11, 1875

7. AGE Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
73	1	16 17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME William Russell

14. BIRTHPLACE (city or town) (State or country) Baltimore Md.

MOTHER

15. MAIDEN NAME Catherine Gross

16. BIRTHPLACE (city or town) (State or country) Baltimore Md.

17. INFORMANT Martin Marcks
(Address) 2824 Walbrook Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Cathedral Date Oct. 6 1948

19. UNDERTAKER Martin Fahey Sons
(Address) 1827 N. Wolfe St.

SEP 30 1948 19 Registrar.
Lester Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/28 1948

22. I HEREBY CERTIFY, That I attended deceased from 4/13 1945 to 9/28 1948

I last saw her alive on 9/28 1948 Death is said to have occurred on the date stated above, at 11 p. m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Myocardial insufficiency	1 hr.
Arteriosclerotic heart disease	3½ yr.
Other contributory causes of importance:	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19..

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Robert G. Ritter M. D.

(Address) 340 W Madison St

OCCUPATION is very important. See instructions on back of certificate.

G67254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W.Va. (b) County
(c) City or town Beckley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ALFRED HICKS

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maude Hicks

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) Feb. 1, 1885

8. AGE: Years 63 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business

FATHER
12. Name Alfred Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Marshall
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 10/1/48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~or crematory~~ Prince
Location Raleigh Co. W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.

19 (a) (Signature of person in charge of disposition) Huntington Williams, MD (Address)

Registered by [illegible] 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948, at 3:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1948 to Sept. 30 1948, and that I last saw h; in alive on Sept. 30 1948.

Immediate cause of death Carcinoma of stomach, postoperative state — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/28/48

Major findings of operation: Carcinoma of stomach

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 9/30/48 M. D.

Dr Buck's Copy

G67255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ardleigh N. Hornic
(c) Hospital or institution: 2075 Rockrose Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2075 Rockrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Gruber

3 (b) If veteran, name war	3 (c) Social Security Account No.
4 Sex: Male	5 Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced	
6 (b) Name of husband or wife: Mae	6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 27 1883

8. AGE: Years 65 | Months 5 | Days 0 | If less than one day: hr. min.

9. Birthplace Pennsylvania (town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER
12. Name Charles B. Gruber
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Eiceman
15. Birthplace Pennsylvania

16 (a) Informant Mrs Anna Bennett
(b) Address 503 East 35th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Road

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 (a) Sept 30, 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept 1948 at 9 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Sept 1948 to 29 Sept 1948, and that I last saw him alive on 29 Sept 1948.

Immediate cause of death: Malignant hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place or public place? While at work?
(Specify)
(e) Means of injury

23. Signature Walter B. Buck M D
Address 18 E. Eager St Date signed Sept 30 48

X

VS 189

G67256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G67256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 HILTON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WILSON TOWNSEND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife VIRTIE TOWNSEND

6 (c) If alive, give age NOT KNOWN years

7. Birth date of deceased (mo., day, yr.) JUNE 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	3	16	hr. min.

9. Birthplace PENNA. (Town, county, and state)

10. Usual Occupation SAFETY ENGINEER

11. Industry or business

FATHER
12. Name SAMPSON TOWNSEND
13. Birthplace ENGLAND

MOTHER
14. Maiden Name CATHARINE RISINGER
15 Birthplace NOT KNOWN

16 (a) Informant WIFE.
(b) Address 3300 HILTON ST BALTO.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn Md

18 (a) Funeral director William Gorsuch
(b) Address 127 St Paul St

30 1948 (c) (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Sept 1948, at 730 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Sept 1948 to 30 Sept 1948. and that I last saw him alive on 30 Sept 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	3 DAYS
Due to PNEUMONIA	3 DAYS
Due to PERITONITIS WITH ABDOMINAL DISTENTION	6 DAYS
Other Conditions POSS. LUNG NEOPLASM	

(Include pregnancy within 3 months of death)

Date of operation 23 Sept 1948

Major findings of operation: STRANGULATED FEMORAL HERNIA, RT.

of autopsy: PNEUMONIA, PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Ferris M. D.
Address MERCY HOSP., BALTO. Date signed 30 Sept 1948

VS 180

G672257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

G672257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 N. Lakewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY CLIFFORD LAUDEMAN

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie Huber Laudeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1868

8. AGE: Years 80 | Months 5 | Days 11 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Pennsylvania R. R. Co.

FATHER
12. Name William H. Laudeman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha A. Hitchcock
15 Birthplace Baltimore, Md.

16 (a) Informant Mr. W. W. Laudeman
(b) Address 12 Belgrove Rd., Catonsville

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Union Cem.
Location Allentown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 30 1948 (b) Hampton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 12:10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 29 1948, and that I last saw h[illegible] alive on Sept 2 1948.

Immediate cause of death Myocardial failure — Duration Sept 29/48
Antecedent myocardiosclerosis
Due to Acute bronchial pneumonia —
Due to Arteriosclerosis —
Other Conditions Emphysema —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Crumrine M. D.
Address 722 Lakewood Ave. Date signed Sept 30/48

VS 150

G67258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G67258

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... Loudon Park
(c) Hospital or institution:
Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. 2
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME CLARA R. SHOEMAKER

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex F | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife Thomas I. Shoemaker
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) June 28, 1868

8. AGE: Years 79 | Months 3 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Hance
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Watkins
15. Birthplace Md.

16 (a) Informant Estelle F. Hance
(b) Address Mt. Airy Md

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Locust Grove Cem.
Location Mt. Airy, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 10-3-48 **(b)** Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 48, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 19 48, to Sept 30 19 48, and that I last saw h[illegible] alive on Sept 19 48.

Immediate cause of death
Cerebral hemorrhage, [illegible]
Due to Coronary Embolism (?)
Due to Extensive [illegible] Coronary Thrombosis
Other Conditions Diabetes [illegible]
(Include pregnancy within 3 months of death)

Duration

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

X

667259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

667259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Bolton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LLOYD L. LEITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Vera Todd Leith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	9	hr. min.

9. Birthplace Appleton, Wis. (Town, county, and state)
10. Usual Occupation Social Eng.
11. Industry or business

FATHER
12. Name Thomas S. Leith
13. Birthplace Scotland

MOTHER
14. Maiden Name Cora B. Briggs
15. Birthplace Appleton, Wis.

16 (a) Informant Mrs. Vera Todd Leith
(b) Address 2101 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 30 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1948 at 11:45 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1948 to Sept 1948, and that I last saw h[illegible] alive on Aug 1948.

Immediate cause of death (Coronary Thrombosis) Duration 3 hrs
Due to Cor. Artery disease Arteriosclerosis 2 yrs
Due to
Other Conditions Diabetes Mellitus 5 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. H. S. Shilling, M. D.
Address 2426 Eutaw Pl Date signed 9/29/48

M S SHILING - M.D. - 94a

VS 150

667260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667260 Registered No.

667260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Overhill Road
(c) Hospital or institution:
None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Always 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Overhill Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hope Harvey Bansell Jr.

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-09-2759

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary Agnes Bansell

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) June 12, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53 52	3	14		

9. Birthplace Chestertown, Maryland (Town, county, and state)

10. Usual Occupation Executive Vice President

11. Industry or business Communications - Radio

FATHER
12. Name Hope Harvey Bansell
13. Birthplace Chestertown Maryland

MOTHER
14. Maiden Name Margaret Spencer Richards
15. Birthplace Chestertown Maryland

16 (a) Informant Robert S. Mish
(b) Address 4302 Keswick (Ave)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1 1948 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Druid Hill Ave. & Dukeland

18 (a) Funeral director Hamburger & Sons
(b) Address North Rd. & Orchard Ave.

19 (a) (b) OCT 1 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941, to Sept 29 1948, and that I last saw him alive on Sept 29 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 15 minutes

Due to: Coronary Arteriosclerosis — 7 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Bluck M. D.
Address 1326 St Paul St Date signed 9/30/48

VS 150

X

667261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 667261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 St. Georges ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 St. Georges ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1. 1877

8. AGE: Years	Months	Days	If less than one day
70	11	1	hr. min.

9. Birthplace Claus. Co. Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Wm Branch
13. Birthplace Claus. Co. Md.

MOTHER
14. Maiden Name Margaret Toger
15. Birthplace Md.

16 (a) Informant Rev. Noble Toger
(b) Address 4502 St. Georges Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Chicago, Ill.

18 (a) Funeral director Wm. T. Chatmon Jr
(b) Address 1201 McCulloh St.

19 OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 2 1948, and that I last saw him alive on Oct 2 1948.

Immediate cause of death Cardiac Renal Disease — Duration Two

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kenneth A. Johnson M. D.
Address 2329 Guilford Ave. Date signed Oct 4 1948

VS 150

667262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 667262

CN. 119788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. City Jail
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 70 ? | Months | Days | If less than one day: hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Blankety ave

19 OGI (Date rec'd by Registrar) 1 1948 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 19 - 1948 at 7.00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 18 -48 to 9- 19- 1948.
and that I last saw him alive on 9- 19- 1948

Immediate cause of death Subarachnoid hemorrhage — Duration 1 mo.

Due to Hypertensive Arteriosclerotic Heart Disease — ?

Due to

Other Conditions

(include) pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Mahan Jr.
Address Balto. City Hosp. Date signed 29 Sep 48.

Write the causes of death clearly and legibly.

67263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167 67263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write township, and give town)
(d) Street No. 2 C olvins St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY WASHINGTON
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
32				

9. Birthplace Accomac Co. Va. (Town, county, and state)
10. Usual Occupation Day Maid
11. Industry or business

FATHER
12. Name Geo. H. Washington
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Sarah N. Samuels
15. Birthplace Va

16 (a) Informant Charles Washington
(b) Address 1109 E Lexington St

17 (a) Burial (b) Date thereof Oct 1/48
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas A Wilson
(b) Address Baltimore
Huntington Williams, M.D.

19 (a) (Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, 3 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A. Subarachnoid hemorrhage and lung
Due to
Other Conditions

22. If an external cause was primary [X] cause of death, fill in the following:
(a) Date of injury Sept. 25/48 2 P.M.
(b) Where did injury occur? In Front of 3[illegible] Forrest St.
(c) Did injury occur at home, on farm, industrial place, in public place? public place No
(d) Means of injury Sharp instrument

23. Signature Carl H. Rogers M.D.
Medical Examiner
Date signed 9/25/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4939 Reisterstown Road.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH CAUGHY

3 (b) If veteran, name war W. W. I

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1892

8. AGE: Months 11 | Days 13 | If less than one day: hr. min.

9. Birthplace: Washington D. C. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Charles S. Caughy
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary Ditzel
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Mary Caughy
(b) Address: 4939 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/2/48 (month)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 W. Saratoga St.

19 (a) Filed: OCT 1 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27, 1948 at 11:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) found that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Comp. Fracture of right tibia and fibula, Fract. skull, Contusion of brain, Intracranial hemorrhage, Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 9-21-48 at Approx. 1 A. M.
(b) Where did injury occur? Reisterstown Road 100' south of Arbutus Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Where was?) no
(d) Means of injury: Pedestrian struck by auto.

23. Signature: George F. Merrill M.D. Medical Examiner.
Date signed 9-28-48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 22da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Spring St. (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Marie Powers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	White	Widow

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. June 24, 1848

8. AGE: Years 100 | Months 2 | Days 6 | If less than one day: hr min

9. Birthplace Mt. Savage, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Maxwell
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, Cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19. (a) OCT 1 1948 (Date rec'd by registrar) Huntington, W. Va. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948, at 12:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/8 1948 to 9/30/ 1948, and that I last saw her alive on 9/30 1948

Immediate cause of death	Duration
Hypostatic	
Due to:	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY Howard Carman, M.D. for M.S. Hagner M.D.

Date of operation

Major findings of operation

of autopsy:

CHIEF OR ASST. MEDICAL PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County)
(d) Did injury occur about home, on farm, industrial place or public place? While at work?
(e) Means of injury

23. Signature Anthony F. D. Pauka
Address St. Joseph's Hospital signed 9/30/48

57266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. (1657 C.M.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Woodbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3409 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Markowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace New York (Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benj. Goldstein
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Harry Markowitz
(b) Address 3409 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendmen
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 1 1948 (Date rec'd by registrar) Huntington Williamsville, W. Va. (b) Address 276 Eutaw Pl. Date signed 9-30-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-48 4:45 M

21. I certify that I last saw the deceased on July 21 '48 and that I last saw deceased alive on Sept 28 '48

Immediate cause of death

Duration

(a) Cerebral Thrombosis 1 month

Due to (b) Alzheimer's disease 3 months

Due to (c)

Other Conditions

Date of operation Aug 7, 1941

Major findings of operation Dilated Entire Ileum

of autopsy:

PHYSICIAN

I attended the deceased from July 21 '48 to Sept 28 '48

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph [illegible] M.D.

Address 276 Eutaw Pl. Date signed 9-30-48

VS 150

67267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G67267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 No Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 No Hilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin [redacted] Hartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Cecilia

6 (c) If alive, give age years

7. Birth date of deceased mo. day, yr 1917

8. AGE: Years 61 | Months | Days | If less than one day hr min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business

FATHER 12. Name Harris, K.

13. Birthplace Russia

MOTHER 14. Maiden Name Bella

15. Birthplace Russia

16 (a) Informant Cecilia Hartz

(b) Address 2703 No Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)

(c) Cemetery or crematory

Location Herring Run

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

10-1 1948 (Date received by registrar) (b) Registrar Huntington Woodward, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 9-30 1948 and that I last saw h[redacted] alive on 9-30 1948

Immediate cause of death: Coronary Thrombosis — Duration: imm.
Coronary Insufficiency — 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin S. Hartz MD

Address 5443 Park Heights Ave Signed 9/30-48

VS 150

67268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67268

Registered No.

157 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Wheaton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 College Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jo Nell Frizen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-48

8. AGE: Years 7 | Months | Days 15 | If less than one day hr. min.

9. Birthplace Ill. (Oak Park)
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Bernard Frizen
13. Birthplace Ill.

MOTHER
14. Maiden Name Berant F. Alfors
15. Birthplace Ill.

16 (a) Informant G. Berent Frizen
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-48 (month) (day) (year)

(c) Cemetery or crematory
Location Chicago, Ill.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

OCT 1 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1948 to 9/30 1948, and that I last saw her alive on 9/30 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Pneumonia Bronchial	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 30, 1948

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature D. P. Cregor M.D.
Address Johns Hopkins Hospital Date Sept 30/48

VS 150

67269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

Registered No. 67269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Rockwood Ave #15 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Reinhold Wm. Dykeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nora Pearl Schaeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 16, 1887

8. AGE: Years 60 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Denmark (Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business couplings

FATHER
12. Name Wm. Dykeman
13. Birthplace Denmark

MOTHER
14. Maiden Name Sophie M. Jes
15. Birthplace Baltimore md.

16 (a) Informant Wm. Dykeman
(b) Address 4200 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2. 45 (month) (day) (year)
(c) Cemetery or crematory Krieders Cemetery
Location Westminster md.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1 Oct 1945 Eutaw Pl.

19 (a) (Date rec'd by registrar) Huntington Williamson, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at 7 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1945 to Sept 29 1945, and that I last saw him alive on Sept 29 1945.

Immediate cause of death	Duration
Pneumonia, Lobular	
Due to Uremia	
Due to Hypertension - Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williamson M.D.
Address Maryland General
Date signed 9/29/45

VS 150

X

67270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193 ✓ Registered No. G67270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Key Highway
(c) Hospital or institution Beth. Steel Company 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Ramsay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAUNDERS G. BINGHAM

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Bessie J. Bingham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1910

8. AGE: Years 38 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Pineville, Kentucky
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Beth. Steel Company

FATHER
12. Name Elias Bingham
13. Birthplace Kentucky

MOTHER
14. Maiden Name Julia Hampton
15. Birthplace Kentucky

16 (a) Informant Bessie J. Bingham
(b) Address 1507 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral Director Pratt & Tucker & B. M. Walker
(b) Address Huntington, W. Va.

19 OCT 1 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-30-48 Approx. 7:30 A.M.
(b) Where did injury occur? Beth Steel Co. ~~[illegible]~~ Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Electrocuted while testing electric drill

23. Signature M.D.
Medical Examiner.

Date signed 9/30/48

VS 151

G67271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G67271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Jordon Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sparated

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June(?) 1908

8. AGE: Years: 40 | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Va.

MOTHER
14. Maiden Name: ?
15. Birthplace: Va.

16 (a) Informant: Pharoah Adams
(b) Address: 100 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Adolphus Halstead

18 (a) Funeral director: 918 Druid Hill Avenue
(b) Address

19 (a) OCT 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1948, at 3 20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-25-48 at Approx. 2:00 P. M.
(b) Where did injury occur? 921 Linden Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's Home While at work? No
(d) Means of injury: Sharp Instrument

23. Signature: Earl L. Kyle M.D. (Medical Examiner)
Date signed 10-1-48

VS 151

G67272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G67272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1856

8. AGE: Years	Months	Days	If less than one day
92			min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Abraham Goodman
13. Birthplace Poland

MOTHER
14. Maiden Name Millie ?
15. Birthplace Poland

16 (a) Informant Charles D Weisberg
(b) Address 3413 Copley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

6.45

20. DATE OF DEATH October 1 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 12 to Oct. 1 1948.
and that I last saw h alive on Sept 30 1948

Immediate cause of death Contract Coronary Arteriosclerosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Meeon B Fink
Address 7320 Eastwood Date signed 10/1/48

VS 150

G67273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Ellamont St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN E. WEEKS

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Samuel H. Weeks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1878

8. AGE: Years	Months	Days	If less than one day
70	5	13	hr. min.

9. Birthplace Emory Church, Harford Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jonas Huff
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Arnold
15 Birthplace Md.

16 (a) Informant Mr. Samuel H. Weeks
(b) Address 1511 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1948. to Sept. 29 1948. and that I last saw her alive on Sept 29 1948.

Immediate cause of death	Duration
Coronary thrombosis	one day
Due to (a) not known (emotional upset)	
Due to	
Other Conditions None for autopsy (b) Transient hypertension	two yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. Fourth Ave Date signed 10/1/48

67274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 67274

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Otterbin St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Julia Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Femal	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1896

8. AGE: Years	Months	Days	If less than one day
52 51	5	26	hr. min.

9. Birthplace Georgetown S.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Washington
13. Birthplace Georgetown S.C.

MOTHER
14. Maiden Name Eleanor Simmons
15 Birthplace Georgetown S.C.

16 (a) Informant Eloulse Parker
(b) Address 313 Otterbin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave

19 (a) OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1948, at 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to 9/28 1948, and that I last saw h alive on 19

Immediate cause of death Chronic Cystic Vesicular Pulmonary Disease

Duration 8 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.

Address 90 Harlington Date signed 10/1/48

67275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 W. University Pky
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. University Pky (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Moale Jenkins

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Chas. T. Jenkins

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Dec 3 1859

8. AGE: Years 88 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

MOTHER / FATHER

12. Name Charles H Dunnock

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Emily L. Moale

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Judith M Warner (daughter)

(b) Address 615 W University Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 48 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md

18 (a) Funeral director Sullivan Memorial

(b) Address 108 W. Mt. Ave.

19. Filed OCT 1 1948 (Date rec'd by registrar) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 September 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to September 1948, and that I last saw h[illegible] alive on 30 September 1948.

Immediate cause of death bronchiectasis chronic, rt — Duration several years

Due to

Due to

Other Conditions General muscle atony senile debility, arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy none.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall Smith, Jr.

Address 623 W. University Pky Date signed 9/30/48

VS 150

G67276 BC = 48-4228 ✓ G67276

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 107

CERTIFICATE OF DEATH

IS-M 9984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ months.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Maryln Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEAN CARROLL GARMAN

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1o, 1948

8. AGE: Years | Months: 4½ | Days: 1 | If less than one day: hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Ambrose Garman
13. Birthplace Penn.

MOTHER 14. Maiden Name Dorothy McKolon
15. Birthplace Md.

16 (a) Informant RECORDS* BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Christ Lutheran Church Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1948, at 12:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-29 1948 to 9-29 1948, and that I last saw her alive on 9-29- 1948

Immediate cause of death: Pneumonia — Duration 6-8 hrs.
Due to: Septicemia — 6-8 hrs.
Due to: organism unknown
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 9-30-48

VS 150

67277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1212

Registered No. 667277

Please write the entries on death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3213 Shannon Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 3213 Shannon Drive
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET BYUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	W	Widow

6 (b) Name of husband or wife Charles A. Byus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	1	16		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name John Gearish

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary E. Bennett

15. Birthplace Germany

16 (a) Informant Mr. Stanley A. Byus

(b) Address 3213 Shannon Drive

17 (a) Burial (b) Date thereof 10/1/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location. Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 OCT 1 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 48 11 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 24 19 48 to Sept 28 19 48.
and that I last saw her alive on Sept 28 19 48

Immediate cause of death Uremia — Duration 5 days

Due to chronic glomerular nephritis — years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Frankie F. Fiske M.D.

Address 1105 St Paul St Date signed Oct 2 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Marshall St. (SOUTH) (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. BURK SR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0720

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife FLORENCE BURK
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 9 - 4 - 1883

8. AGE: Years	Months	Days	If less than one day
65	--	24	---hr.------ min.

9. Birthplace WILMINGTON DELAWARE (Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business BAKER WHITTING COAL CO

FATHER
12. Name JOHN BURK
13. Birthplace DELAWARE

MOTHER
14. Maiden Name ALVERTA LEPPY
15. Birthplace MARYLAND

16 (a) Informant MRS. ROBERT HAIRSINE (DAUGHTER)
(b) Address 1228 S. MARSHALL STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 2/48 (month) (day)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE ..17

19 OCT 1 1948 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948 at 9:55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
Include pregnancy within 3 months of death.

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What kind of work?)
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed

X

67279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. 67279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Patapsco Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLETCHER COX

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband/wife Genevieve Melva Cox
6 (c) If alive, give age 32 years

7. Birth date of deceased mo., day, yr. March 7, 1910

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Florida
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Fletcher Cox
13. Birthplace North Carolina

MOTHER
14. Maiden Name Susan Partilen
15. Birthplace Georgia

16 (a) Informant Mrs Gertrude M. Cox
(b) Address 626 Patapsco Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny Inc
(b) Address 715 Light St.

19 OCT 1 1948 Huntington Williams
(Date rec'd by registrar) Registrar

VS 753

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/48 at 8 40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/20/48 to 9/29/48 and that I last saw him alive on 9/29/48

Immediate cause of death
(1) Shock — Duration

Due to (2) Hemorrhage

Due to (3) Ruptured Esophageal Varix

Other Conditions (4) Portal Cirrhosis
(5) Eczematoid dermatitis
(Unless in pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: (2) + (4)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature William J. Haun, M.D.
Address South Baltimore Gen. Hosp. Date signed
Baltimore 30, Md. 9/30/48

667250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 667250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.s.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Milford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY O'NEILL PRENDERGAST

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-7330

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hanorah K. Prendergast

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1906

8. AGE: Years 42 | Months 7 | Days 7 17 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business James Robertson Mfg. Co.

MOTHER / FATHER

12. Name John A. Prendergast

13. Birthplace Baltimore, Maryland

14. Maiden Name Anna O'Neill

15. Birthplace Ireland

16 (a) Informant: Mrs. Hanorah K. Prendergast

(b) Address 3604 Milford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Maryland

18 (a) Funeral director E. Willis Lamoreau

(b) Address 4510 Liberty Heights Avenue

19 OCT 1 1948 (Date rec'd by Registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured neck
Fractured skull
Intracranial hemorrhage
Contusion of brain
Fracture of femur
Rupture of aorta
Ruptured diaphragm
Fractured ribs and facial bones

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-29-48 at 1:20 P. M. 4/1

(b) Where did injury occur? 106 Hopkins Place

(c) Did injury occur at: home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Fell down elevator shaft

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 9/30/48

VS 151

G67281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67281 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8808 Ridge Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles High

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Laura L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-19-85

8. AGE: Years 62 | Months 10 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Steam Plumber

11. Industry or business H.B. Kiel

FATHER
12. Name Alfred Hugh
13. Birthplace Balt

MOTHER
14. Maiden Name ~~Ruth Kline~~ Alice Raughmaugh
15. Birthplace Balto.

16 (a) Informant Mrs Ruth Kline
(b) Address E. Joppa Rd Fullerton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 OCT 1 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1948 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1948 to 9-29-1948 and that I last saw him alive on 9-29-1948.

Immediate cause of death Bronchopneumonia, Duration 6 hrs.
Due to Cerebral Hemorrhage, Duration 8 hrs.
Due to Cerebral Hypertension, Duration 1 yr.
Other Conditions Chronic nephritis, Duration 1 year
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature Allyn P. Judd M.D.
Address Mercy Hospital Date signed 9-29

VS 150

83a

G67282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 128

G67282
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles Street
(c) Hospital or institution:
Doctor's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM R. WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr) December 4, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Tavern

FATHER
12. Name Walter Bialoskurski
13. Birthplace Poland

MOTHER
14. Maiden Name Ksawera Wasniewska
15. Birthplace Poland

16 (a) Informant Mrs. Elizabeth White
(b) Address 3031 Shannon Drive

17 (a) Burial (b) Date thereof 10/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) OCT 1 1948 Arlington Millspaugh
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 3 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26-1948, to 9-29 1948.
and that I last saw h in alive on 9-29 1948.

Immediate cause of death
Acute Pancreatitis — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9-27-48

Major findings of operation:
Acute Pancreatitis & Peritonitis

of autopsy: general

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Bonfield

Address 5407 Belair Rd Date signed 9-30-48

VS 150

G67283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 P

Registered No. G67283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 E. Overlea Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. BARBARA LONG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife WALTER LONG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT 17, 1880

8. AGE: Years	Months	Days	If less than one day
68	0	12	hr. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name JOHN POSPOSL
13. Birthplace BERLIN, GERMANY

MOTHER
14. Maiden Name BARBARA SMITHSEL
15. Birthplace BOHEMIA

16 (a) Informant HUSBAND
(b) Address SAME AS DECEASED

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood 10/4/48
Location Baltimore, Md.

18 (a) Funeral director Lansdowne Funeral Home
(b) Address 7601 Belair Rd.

19 (a) OCT 1 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 SEPT 1948, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 SEPT 1948 to 30 SEPT 1948 and that I last saw HER alive on 30 SEPT 1948.

Immediate cause of death CARDIORESPIRATORY FAILURE
Due to CARCINOMA OF THE STOMACH WITH WIDE-SPREAD PERITONEAL METASTASIS, JEJUNAL OBSTRUCTION, AND MARKED CACHEXIA
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 2 hours / 1 YEAR?

Date of operation
Major findings of operation:
of autopsy: EXTENSIVE ABDOMINAL CARCINOMATOSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen. Hosp. Date signed 30 Sept 48

VS 153

G67284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. G67284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Bentlou St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Bentlou St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN YOB.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	WIDOWED

6 (b) Name of husband or wife VIRGIL YOB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 4, 1897

8. AGE: Years	Months	Days	If less than one day
51	7	27	hr. min.

9. Birthplace Shamokin, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Celeste Menagace
13. Birthplace Tyrol, Italy

MOTHER
14. Maiden Name Celesta Pasquin
15 Birthplace Tyrol Italy

16 (a) Informant Leonard Yob
(b) Address 1503 Bentlou St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Mt Carmel Penna

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St Baltimore

19 (a) OCT 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948. at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Oct 1 1948.
and that I last saw her alive on Sept 30 1948.

Immediate cause of death	Duration
Cardiac Regulatory Failure	12 hrs
Due to Metastatic Carcinoma	5 mos
Due to Carcinoma of the Breast, Metastatic	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R Ziegler M. D
Address 3723 Edmondson Ave Date signed

VS 150

667285

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp., Balt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) about same

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Fairmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-6729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Separated

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31. 1905

8. AGE: Years	Months	Days	If less than one day
43	1	20	hr. 1 min.

9. Birthplace Meadville Pa (Town, county, and state)
10. Usual Occupation Yard Conductor & Master
11. Industry or business B&O RR

FATHER
12. Name Okey J Moore
13. Birthplace W Va

MOTHER
14. Maiden Name Minnie Watkins
15. Birthplace W Va

16 (a) Informant W J Moore
(b) Address Fairmont W Va

17 (a) Burial, cremation, or removal Fairmont (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Fairmont W Va
Location Fairmont W Va

18 (a) Funeral director Wilson Moore
(b) Address 124 Pr Court St

19 (a) OCT 1 - 1948 (Date rec'd by registrar) Huntington W Va (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1948, to 9/30 1948, and that I last saw h alive on 9/30 1948.

Immediate cause of death	Peripheral Vascular Collapse	Duration
Due to	Cardiac failure while undergoing treat. for Hepatitis	
Due to	Cardiac failure to Digitalis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 11/30/48
Major findings of operation: Metast. ca to liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M.D.
Address University Hosp. Balt. Date signed

VS 150

67286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Home Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town White Marsh (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
87	4	—	hr. min.

9. Birthplace Not known (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Chandler
13. Birthplace Not known

MOTHER
14. Maiden Name Elizabeth Coffee
15. Birthplace Not known

16 (a) Informant: Leonard Birchead
(b) Address Annapolis - Maryland

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Laurel Hill
Location Philadelphia, Pa.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address 4905 Belair Rd.

19 (a) OCT 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 30 - 1948, at 2.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 27 1948, to Sept - 30 1948, and that I last saw h[illegible] alive on Sept - 30 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Myocardial Infarction	2 weeks
Due to Arteriosclerosis generalized	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Hospital Date signed IX-30-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

VS 150

067287

GM. 123047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

Registered No. 067287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 Hughes ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Hudson (William Henry Hudson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
58 ?			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? William H. Hudson
13. Birthplace ? Va.

MOTHER
14. Maiden Name ? Martha
15. Birthplace ? Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cemty
Location Balto.

18 (a) Funeral director Balto B. Bruce
(b) Address 19? W. Hamburg St.

19 OCT 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 18 - 1948, at 9.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 17 - 1948, to 9- 18 - 1948, and that I last saw h im alive on 9-18- 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration ???
Due to PNEUMONIA RT. LUNG — ???
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. P. Jernigan, M.D.
Address BALTIMORE CITY HOSP Date signed 10-1-48

VS 150

667288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

667288
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Woodlea Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Woodlea Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS IDA KEYS LAWLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William Andrew Lawlor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 70			hr. min.

9. Birthplace Anderson, S. C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm Walters Keys
13. Birthplace South Carolina

MOTHER
14. Maiden Name Vashti Burriss
15. Birthplace South Carolina

16 (a) Informant Cpt. Wm K. Lawlor
(b) Address 4010 Woodlea Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/3/48 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville, S. C.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 OCT 1 1948 (Date rec'd by Registrar) Washington Metropolitan

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1st 1948, at 7:30 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Oct.~~ Sept. 28 1948, to Oct. 1st 1948, and that I last saw her alive on Sept 28 1948.

Immediate cause of death Cancer, metastatic — Duration six months

Due to Cancer, breast — 8 years

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ferdinand E. Christe M. D.
Address 1300 N. Calvert St. Date signed Balto. 2, Md.

VS 15.

G67289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67289

1. PLACE OF DIATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 239 days
(e) Length of stay in Baltimore (yrs., mos., or days) 239 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Abingdon (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUSSELL EUGENE CORRELL

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 218-09-8676

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of ~~husband or~~ wife Amelia Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 9, 1883

8. AGE: Years 65 | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business

FATHER
12. Name John Correll
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Alice Sluss
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 2 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948, at 11:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948 to Sept. 30 1948, and that I last saw him alive on Sept. 30 1948.

Immediate cause of death Carcinoma, epiglottis with metastases to cervical lymph nodes and

Due to tissue of left side of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration 1½ yrs

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 10/1/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 62290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamptnett Ave.
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo. 11 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ines Emma Stange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William Stange
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 19 1862

8. AGE: Years	Months	Days	If less than one day
82	10	11	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William Schetlick
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Bentschel
15. Birthplace Germany

16 (a) Informant Mrs. Mary Lehr
(b) Address 5110 Wesley Ave Howard Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4 1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Bur.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Sykes
(b) Address 1605 W. North Ave

19 OCT 2 1948 Clayton Williamson (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948 at 3-35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1943 to Sept 30 1948. and that I last saw her alive on Sept 30 1948.

Immediate cause of death Uremia — Duration 3 mos

Due to nephrosclerosis and arteriosclerosis — Duration years

Due to Diabetes — Duration many years

Other Conditions Myocardial infarction auricular fibrillation — Duration 3 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Edward Luetscher M. D.
Address 12 E Eager St Balto 15 Date signed Oct 2 1948

VS 153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 W Northave 16
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write (U) (R) and give town)
(d) Street No. 2919 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma R Kerr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.
6 (b) Name of husband or wife Anthony J Kerr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 24 1874
8. AGE: Years 74 | Months 10 | Days 6 | If less than one day hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Housewife

FATHER
12. Name James T Hickey
13. Birthplace England.

MOTHER
14. Maiden Name Sarah Fox.
15. Birthplace Pa.

16 (a) Informant Anthony J Kerr.
(b) Address 2919 W Northave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md.
18 (a) Funeral director Foley & MacDonald
(b) Address Catonsville Md.
19 OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948. at 11 30 a M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948. to Sept 30 1948.
that I last saw h[illegible] alive on Sept 29 1948.

Immediate cause of death: Coronary thrombosis — Duration about 3 days
Due to arterio-sclerosis — ?
Due to
Other Conditions Diverticulitis - (Colon) — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Walter Stuart M. D.
Address 220 Garrison Blvd. Date signed Oct 2 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 1667292

1667292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hr. 40min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. MARKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	5 6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Henry Hiltner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wagner
15. Birthplace Baltimore, Maryland

16 (a) Informant John F. Markins
(b) Address 1224 W. Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3891 Frederick Avenue

18 (a) Funeral director JOHN J. COWAN & SON
(b) Address 901-03 Hollins Street

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Mar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd° Burns 80% Body

Due to

Other Conditions Epilepsy

(Include pregnancy within 3 months of death)

22. If an external cause was primary X, or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/30/48 X 5:30 P.M.
(b) Where did injury occur? 1224 W. Cross Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home (Specify in each case)
(d) Means of injury Had epileptic attack & fell into lighted stove

23. Signature John Edwards, M.D. Medical Examiner.
Date signed 10/1/48

VS 131

667293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 E

Registered No. 667293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County BWI
(c) City or town Trinidad
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Duke St
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Spain

3 (a) FULL NAME Michael Sun Soy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	yellow	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/40

8. AGE: Years	Months	Days	If less than one day
7	11	22	hr. min.

9. Birthplace Trinidad (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Sun Soy
13. Birthplace China

MOTHER 14. Maiden Name Dorothy Chow Juan
15. Birthplace Trinidad

16 (a) Informant Francis Chow Juan
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 2 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Uelrich Funeral Home
(b) Address 2626 Gleans St

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948 at 5 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1948 to 10/1 1948 and that I last saw him alive on 10/1 1948

Immediate cause of death: Brain Tumor — Duration: one year

Due to

Due to

Other Conditions CRANIO PHARYNGIOMA
(Include pregnancy within 3 months of death)

Date of operation Sept 28 1948

Major findings of operation: Cranio Pharyngioma

of autopsy: Cranio Pharyngioma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Maurice L Silver M.D.
Address Johns Hopkins Date signed 10/1/48

VS 159

667294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667294

49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: St. Joseph's HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town SPARROW'S POINT (If outside city or town limits, write RURAL and give town)
(d) Street No. BOX 60 ROUTE 10. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY OSTAPIUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 18[illegible]

8. AGE: Years	Months	Days	If less than one day
56	9	21	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stanley Graczyk
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Helen Ostapiuk
(b) Address Box 60 Route 10 Sparrows Pt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 1007 Eastern Ave

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948 at 2 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1948 to Sept. 30, 1948. and that I last saw her alive on Sept. 30, 1948.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. (M.D.)
Address St. Joseph's Hospital Date signed 9-30-48

VS 150

667295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 667295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk.Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 11 days
(e) Length of stay in Baltimore (yrs., mos., or days): 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: DC (b) County:
(c) City or town: Washington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1007 - 4th St. NE (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country:

3 (a) FULL NAME: TONY DI MATTEO

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 578-01-7492

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Philomenia Di Matteo
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 28, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	8	3		

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Tile setter
11. Industry or business:

MOTHER / FATHER
12. Name: Domenia Di Matteo
13. Birthplace: Italy
14. Maiden Name: Philomenia ?
15. Birthplace: Italy

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct 2.48 (month) (day) (year)
(c) Cemetery or crematory: Washington D.C.
Location: Washington D.C.

18 (a) Funeral director: W.W. Chambers Co
(b) Address: Washington D.C.

19 (a) OCT 2 - 1948 (Date rec'd by Registrar) (b) Washington D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1948 at 12:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Oct. 1 1948, and that I last saw him alive on Oct. 1 1948.

Immediate cause of death: Brucellosis — Duration: 2 Yrs.
Due to: Vegetative, stenosing, aortic valvulitis with cardiac hypertrophy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon, M. D.
Address U.S. Marine Hospital, D.C. Signed 10/2/48

VS 150

667296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

667296 Registered No.

Physicians: please write the causes of death clearly and legibly. Correct age is especially important. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1949 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Culp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Catherine Culp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Con. Gas & Electric Co.

FATHER
12. Name Harry T. Culp
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Courts
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Culp
(b) Address 1949 W. Mulberry St.

17 (a) Burial (b) Date thereof Oct. 4/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2330 Frederick Rd.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 47 to 9-29-48 19
and that I last saw him alive on 9-29-48 19

Immediate cause of death Bronchiectasis — Duration 2yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature D. S. Shanahan M. D.
Address 1945 W. Baltimore St. Date signed 9-30-48

VS 150

67297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67297

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2919 Edmondson Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2919 Edmondson Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Franklin Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-9799

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1948

8. AGE: Years 70 | Months | Days 15 | If less than one day hr. min. 1878

9. Birthplace Salem Virginia (Town, county, and state)

10. Usual Occupation Mining Engineer

11. Industry or business Retired

FATHER 12. Name William Thompson

13. Birthplace Virginia

MOTHER 14. Maiden Name Sprouse Davies

15. Birthplace Virginia

16 (a) Informant Harry E Thompson

(b) Address 3108 Gilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Balto Co Md.

18 (a) Funeral director Lansing Byers

(b) Address 3005 Park Heights Ave

19 OCT 2 - 1948 (Date rec'd by registrar) Certificate No. 67297

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to 9-29 1948 and that I last saw him alive on 9-29 1948

Immediate cause of death Coronary occlusion

Due to Hypertension or Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 36 hours, years, years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William L. Thompson M. D.

Address 3025 Belair Road Date signed 10-1-48

VS 180

67298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 67298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 N. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Manor Hubin

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Thomas Mathew Hubin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1909

8. AGE: Years	Months	Days	If less than one day
39	6	25	hr. min.

9. Birthplace Mississippi
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William T. France
13. Birthplace Md.

MOTHER
14. Maiden Name Etta E. Jones
15. Birthplace Md.

16 (a) Informant Mr. Thomas M. Hubin
(b) Address 3713 N. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum Gen.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948 at 8:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Sept 1948 to 30 Sept 1948 and that I last saw h alive on Sept 30 1948.

Immediate cause of death Peripheral vascular collapse - Cardio-respiratory arrest.
Due to Rheumatic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Tuchen M.D.
Address West Baltimore Gen'l Hosp Date signed Sept 30 1948

VS 150

667299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667299
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 W. 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE MAY FICKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife George Ficke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Amos C. Wilson
13. Birthplace Rising Sun, Md.

MOTHER
14. Maiden Name Elizabeth Waterworth
15. Birthplace Baltimore, Md.

16. (a) Informant Mrs. Elizabeth Marsh
(b) Address 1743 Park Ave.

17 (a) Burial (b) Date thereof 10.4.48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 4 - 1948 (b) Signature for Registrar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1948 at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Oct 1 1948, and that I last saw her alive on Oct 1 1948.

Immediate cause of death Cerebral thrombosis — Duration 4 da

Due to Arteriosclerosis, generalized — 15 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address 11 W. 29th ST Date signed Oct 2, 1948

VS 150

667300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. 667300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Bernard Aul

3 (b) If veteran, name war No

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	24	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation City Employee

11. Industry or business Balto. City Govt.

FATHER 12. Name John Aul

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary E.

15. Birthplace Germany

16 (a) Informant Miss Catherine A. Crosbie

(b) Address 1136 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location 4430 Belair Rd

18 (a) Funeral director Edward W. Conklin

(b) Address 924 E. Eager St Huntington Williams, Md.

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1948 at 3 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Sept 28 1948, and that I last saw him alive on Sept 28 1948.

Immediate cause of death Carcinoma of Stomach — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Keane M. D.

Address 1105 N. Charles St Date signed Oct 1, 48

V S 150

G67301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67301

Registered No. 95R

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparks
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edna BELLE JACKSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	married

6 (b) Name of husband or wife Cornelius Jackson
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept 20. 1896

8. AGE: Years 52 | Months — | Days 12 | If less than one day: hr. min.

9. Birthplace Moulstown, Balto Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George H. Harris
13. Birthplace Moulstown, Md.

MOTHER
14. Maiden Name Elizabeth Asbith
15 Birthplace Virginia

16 (a) Informant Mrs. Cornelius Jackson
(b) Address Sparks, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10 4-48 (month) (day) (year)
(c) Cemetery or crematory St. Lukes A.M.E.
Location Sparks, Md.

18 (a) Funeral director J. M. Brooks
(b) Address Sparks, Md.

1948 OCT 3 - 1948 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-48 19 . at 6 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-48 19 , to 10-2-48 19 , and that I last saw h er alive on 10-2-48 19 .

Immediate cause of death Coronary Failure — **Duration**

Due to Subacute bacterial endocarditis

Due to Rheumatic Heart disease

Other Conditions Embolism - left leg, possible cerebral.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subacute Bacterial Endocarditis
Numerous emboli

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Roberts M. D.
Address West. Md. Date signed 10-2-48

VS 150

667302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmett Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Harris
13. Birthplace Va

MOTHER 14. Maiden Name Ann Harris
15. Birthplace Va

16 (a) Informant Mrs Clifton Harris
(b) Address 1618 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3-48 (month) (day) (year)
(c) Cemetery or crematory Memorial Cem.
Location Petersburg Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

OCT 3 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Sept~~ Oct 1 1948, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1948, to Oct 1 1948, and that I last saw him alive on Sept 15 1948.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis (Coronary) 1 yr.

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. E. Burwell
Address 171 Aisquith St Date signed 10-2-48 M D

VS 150

G67303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G67303
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2131 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 W. Baltimore St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Leven Wooters

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-16-6623

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Separated
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 3, 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	7	28		

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Riveter
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Daniel Leven Wooters
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rose Walters
15. Birthplace: Maryland

16 (a) Informant: Laura Irene Wright
(b) Address: 2131 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Maryland
Location Baltimore, Maryland

18 (a) Funeral director: George F. Schwaber
(b) Address: 2104 Pennsylvania Avenue

OCT 3 1948 (Date registered) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 8 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 10/1 1948 and that I last saw him alive on 10/1 1948

Immediate cause of death: Carcinoma of Lung (Pt)
Duration: 2 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8/1/48
Major findings of operation: Carcinoma of at lung
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Benjamin Miller, M. D.
Address: 2030 Wilkens Ave
Date signed: 10/2/48

VS 150

667504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667504

127a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Finksburg Rt #1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Carroll Haines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct 14 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
72	11	18		

9. Birthplace Carroll County Maryland (Town, county, and state)
10. Usual Occupation Carpenter retired
11. Industry or business

FATHER
12. Name Abraham Haines
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Margaret Eckman
15. Birthplace MARYLAND

16 (a) Informant Mary E. Haines
(b) Address Finksburg Rt #1 Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 5 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant Cem.
Location GAMBER, MD.

18 (a) Funeral director JOHN R. BYERS
(b) Address WESTMINSTER, MD.

19 (a) OCT 3 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 1948 at 6:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-21 1948 to 10-2 1948 and that I last saw him alive on 10-2 1948.

Immediate cause of death	Duration
Cardio-resp failure	
† anemia	3-4 wks
Due to post-operative transmethral resection	
Due to alco gangrenous vesical cancer.	
Other Conditions Benign prostatic hypertrophy	

(Including pregnancy within 3 months of death)

Date of operation 10-1-48

Major findings of operation: Benign prostatic hypertrophy

of autopsy: not granted

PHYSICIAN (Underline the one to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard E. Martin M.D. M. D.
Address Maryland Gen. Hosp. Date signed 10-2-48

VS 193

G67305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John S. Corcoran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1865

8. AGE: Years 83 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Frank Corcoran
13. Birthplace Aboard Ship, U.S. Water

MOTHER
14. Maiden Name Rebecca Sheppard
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mitchell Son
(b) Address 90 W. Lafayette Ave. Baltimore 17, Md.

OCT 3 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1948 at 9:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Oct 2 1948 and that I last saw him alive on Oct 2 1948.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions Art. sclerosis
Art. sclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature F. Shumsla
Address Mercy Hosp. Date signed 10/2/48 M D

VS 199

1092

667306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 667306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Norfolk Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Louis Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Mary Cohen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name ~~Mr. Louis~~ Jacob
13. Birthplace ~~Russia~~ Russia

MOTHER
14. Maiden Name ~~Mrs. Louis~~ Sophie
15. Birthplace Russia

16 (a) Informant Mary Cohen
(b) Address 3313 Norfolk Ave

17 (a) Burial (b) Date thereof 10-3-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2106 Eutaw Place

Oct 1948
(Date rec'd by registrar)

(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948 at 8:26 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1948 to Oct. 3, 1948 and that I last saw h im alive on Oct. 3, 1948

Immediate cause of death Coronary Occlusion — Duration 24 hr.

Due to Arteriosclerotic Heart Disease — Duration yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John R. Smith Jr. M. D.
Address Union Memorial Hosp. Date signed 10/5/48

VS 139

667307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121B

Registered No. 667307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 No. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Schuster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	M

6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45				

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Kamerow
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Max Schuster
(b) Address 2014 N Charles St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 10-3-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 106 Eutaw Place

OCT 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1948, at 1:20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/28 1948 to 10/1 1948, and that I last saw her alive on 10/1 1948.

Immediate cause of death	Duration
pulmonary Edema	
Due to Hypertensive Ht Disease	
Arteriosclerotic Ht. Disease	
Due to Chronic Glomerulonephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marjorie Duncan M.D.
M. D.
Address Sinai Hosp Baltimore Date signed 10/1/48

VS 150

667308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667308

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hours
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HEPNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-7261

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Evelyn Ely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1882

8. AGE: Years 66 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bank

FATHER 12. Name Asa Hepner

13. Birthplace Md

MOTHER 14. Maiden Name Hettie Warfield

15. Birthplace Md

16 (a) Informant Mrs Evelyn Hepner

(b) Address Sykesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery or crematory Springfield

Location Sykesville, Md

18 (a) Funeral director C. Harry Weer

(b) Address Sykesville, Md.

19 (a) Huntington Williamsport (Date rec'd by registrar) OCT 3 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 2 1948, and that I last saw h[im] alive on Oct 2 1948.

Immediate cause of death	Duration
Cardiac Arrest	
Due to Coronary infarction	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Shaer

Address Univ Hospital Date signed 10/2/48

VS 150

G67309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 E

Registered No. G67309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMIRA NORRIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: James F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 20, 1875

8. AGE: Years	Months	Days	If less than one day
73	4	10	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John R. Scroggs
13. Birthplace: Md

MOTHER
14. Maiden Name: Almira Hart
15. Birthplace: Md

16 (a) Informant: Edith Collins
(b) Address: 1621 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Crematory: Parkwood
rkville, Md.

18 (a) Undertaker or: William Cook, Inc
(b) Address: 1217 St. Paul St.

OCT 2 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Sept 30 1948 and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	Unknown
Due to Thrombocytic Purpura	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify (yes or no) place)
(e) Means of injury:

23. Signature Helen Ellerson
Address 10 Edmondson Ave Date signed 10/1/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Medford B. Mann

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-22-2005

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rena P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1890

8. AGE: Years 57 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER 12. Name Thomas Mann

13. Birthplace Md.

MOTHER 14. Maiden Name Mary B. Wilmer

15. Birthplace Md

16 (a) Informant Mrs Rena P. Mann

(b) Address 2011 N. Charles St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc

(b) Address 1217 St. Paul St.

(Date rec'd by registrar) OCT 8 1948 (b) Huntington Macaulay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1948 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948 to 10/2 1948 and that I last saw him alive on 10/2 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebro vascular accident	
Due to Hypertension, severe	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Black M. D.

Address Maryland General Date signed 10/7/48

VS 150

667311 ✓ 667311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 667311

667311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Clyde Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-18-5721

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 11 1870

8. AGE: Years 78 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Cameron Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15 Birthplace "

16 (a) Informant Mrs Nellie Shaffer

(b) Address 222 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John C. Mellyn Inc

(b) Address 2436 E. Oliver St Baltimore Md

19 (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 1948 at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 30 1948, to OCT 2 1948, and that I last saw h(im) alive on OCT 2 1948.

Immediate cause of death: CORONARY THROMBOSIS — Duration: 2 DAYS.

Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE — Duration: —

Due to

Other Conditions MYOCARDITIS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature James F Kavanagh M.D.

Address 304 W McElderry St Date signed 10-2-48

VS 150

G67312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G673127

Registered No. 927

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 26 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3906 Fairhaven Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME CECILIA H. WHITAKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clinton H. Whitaker

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 9-12-1886

8. AGE: Years 62 Months Days 18 If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Dawson

13. Birthplace Cecil Co. Md.

MOTHER 14. Maiden Name Mary Ann Edwards

15. Birthplace Georgetown Ward Md.

16 (a) Informant Clinton H. Whitaker

(b) Address 3906 Fairhaven Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John C. Miller Inc

(b) Address 2434 E. Oliver St

OCT 6 - 1948 (Date rec'd by registrar)

(b) Funeral Home Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1948 at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-28 1948 to 9-30 1948 and that I last saw her alive on 9-30 1948

	Duration
Immediate cause of death: Pulmonary Edema	1 day
Due to Cardiac Failure	2 days
Due to Coronary Occlusion Due to Arteriosclerotic CV Disease	3 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward H. Kaufman M.D.

Address 1213 Light St. Date signed 9-29-48

VS 153

667313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

667313 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Overlea (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Leslie Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Antonette Paul

3 (b) If veteran, name war

3 (c) Social Security Account No. 258-05-4994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James T. Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 12 1917

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Strickland
13. Birthplace Va.

MOTHER
14. Maiden Name Ewala MacMillan
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Frederick Smith, Inc
(b) Address 3014 E. Monument St

BCI 3-1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 19[illegible], at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 19[illegible] to 10-1 19[illegible], and that I last saw h[illegible] alive on 10/1 19[illegible].

Immediate cause of death GASTRO-INTESTINAL HEMORRHAGE, MASSIVE — Duration

Due to CARCINOMA BARTHOLINS GLAND with METASTASES TO — 10 mos

Due to ABDOMINAL VISCERA, RETROPERITONEAL STRUCTURES

Other Conditions GASTRO-INTESTINAL HEMORRHAGE (Include pregnancy within 3 months of death)

Date of operation DEC. 12, 1947

Major findings of operation: CARCINOMA BARTHOLINS GLAND with METASTASES

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Vincent Hanson, M.D. M.D.
Address Johns Hopkins Hosp Date signed 10/1/48

VS 150

667314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

667314 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 S Clinton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 10 1878

8. AGE: Years 70 | Months 8 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Cr House

FATHER 12. Name James Hadaway
13. Birthplace Md

MOTHER 14. Maiden Name Precilla Sinclair
15. Birthplace Md

16 (a) Informant Miss Lillian Thomas
(b) Address 3306 E Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilbur Funeral Home
(b) Address 200 E Orleans St

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1948 at 2 48 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 1 1948
and that I last saw her alive on Oct 1 1948

Immediate cause of death — Duration
Arteriosclerotic cardiovascular disease
Due to Arteriosclerosis
Due to
Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gorsuch M. D.
Address 147 East Ave Date signed 10-2-48

VS 150

93D

CERTIFICATE CORRECTED 9-1-50 67315

To be CKed by Medical [illegible] CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH

(67315) Case 123403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 St. Paul Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Duffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Della Duffy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years 76 | Months | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 3 - 1948 (Date rec'd by reg.) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/1 19 48 at 1:00 AM (1325) Hrs.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 19 48 to 10/1 19 48. and that I last saw him alive on 10/1/ 19 48.

Immediate cause of death: Pulmonary edema — Duration: 2 days

Due to Arteriosclerotic Heart Disease — Duration: ?

Due to — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Vickers M.D.
Address Balto City Hosp Date signed 3 Oct 48

CERTIFICATION APPROVED BY

[illegible] M.D.
CHIEF OR ASST. MEDICAL EXAMINER

VS 150

667316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

✓ 667316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Ann Petty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 - 1872

8. AGE: Years 76 | Months — | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James J. Petty
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Gallagher
15. Birthplace Ireland

16 (a) Informant John A. Gallagher
(b) Address 1407 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (b) (Date rec'd by registrar) (Registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1948 to Sept 30 1948 and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death.	Duration
Chronic Endocarditis	6 mos
Due to Pulmonary Oedema	2 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 279 Hilleman M. D. Date signed 10/2/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667317

667317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Sallie Hopkins Gray
3 (b) If veteran, name war —
3 (c) Social Security account No. —

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced widowed
6 (b) Name of husband or wife Dead Wells Gray
6 (c) If alive, give age — years
7. Birth date of deceased mo. unknown day unknown yr November 12, 1883.
8. AGE: Years 64? Months 10 Days 18 If less than one day hr — min —
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name unknown
13. Birthplace South Carolina Tupelo Walton?

MOTHER
14. Maiden Name unknown
15. Birthplace South Carolina

16 (a) Informant Sarah Minis
(b) Address 1222 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3, 1948. (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location —

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3237 Lafayette St. Washington D.C.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/48 1948 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1948 to 9/30/48 and that I last saw h[illegible] alive on 9/30/ 1948.

Immediate cause of death Pericardial Tamponade due to Dissecting aneurysm of Abdominal Aorta

Due to generalized Arteriosclerosis

Due to Pulmonary Edema and congestion

Other Conditions Caloric Pernicious Congestion of Liver & Spleen

(Include pregnancy within 3 months of death)

Duration approximately 3 weeks

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature S. E. Brady, Jr M.D.
Address — Date signed — M. D.

VS 150

667518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

667518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROY FLETCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife ROSE BEAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 2 1948 (illegible)

8. AGE: Years 39 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM FLETCHER
13. Birthplace FORSYTHE CO. N. CAROLINA

MOTHER
14. Maiden Name PERMILA COBBLER
15. Birthplace FORSYTHE CO, N. CAROLINA

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10/3/48 (month)
(c) Cemetery or crematory WINSTON SALEM N. C.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address NORTH & PENNSYLVANIA AVES.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Washington Williamson, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 1:40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of liver, Hemorrhage & multiple fractures of ribs, rt.

Due to

Other Conditions Compound fracture of R. tibia & fibula

(Include pregnancy within three months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following.
(a) Date of injury 10-1-48 at 11:20 P M.
(b) Where did injury occur? Route #1, Dorsey, Md.
(c) Did injury occur at home, on farm, in industrial place or public place? public While at work? no
(d) Means of injury? pedestrian struck by auto

23. Signature Earl K. Royer M.D. Medical Examiner.
Date signed 10-2-48

VS 151

Please write the causes of death clearly and legibly. Physicians, please write the causes of death clearly and legibly.

667319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667319

49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rock Hall Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Davis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 7 - 1909

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Carroll.
13. Birthplace Md

MOTHER
14. Maiden Name Mary Cater.
15. Birthplace Md

16 (a) Informant James Davis
(b) Address Rock Hall Ed. 3381

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall Md

18 (a) Funeral director Edgar L. Lane
(b) Address Church Hill, Md

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntingtown Maryland Registrar

VS 1-53

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948 at 12 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/29 1948 to 10/3 1948, and that I last saw him alive on 10/3 1948

Immediate cause of death	Duration
CARDIO - RESPIRATORY FAILURE	
Due to PULMONARY EMBOLISM	
Due to BILATERAL OVARIAN CARCINOMA & GENERALIZED	
Other Conditions ABDOMINAL METASTASIS	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Shaw M. D.

Address St Agnes Hosp Date signed 10/4/48

667320

AB-123251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. 667320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Eugene Jeffries~~ EUGENE JEFFERIES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	? SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) ?-?-? 1868

8. AGE: Years	Months	Days	If less than one day
83?			hr. min.

9. Birthplace ? BALTIMORE, MD (Town, county, and state)
10. Usual Occupation ? EMPLOYEE OF
11. Industry or business CITY OF BALTIMORE

FATHER
12. Name ? JOHN J. JEFFERIES
13. Birthplace ? BALTIMORE, MD.

MOTHER
14. Maiden Name ? ELIZABETH SCHAEFFER
15. Birthplace ? BALTIMORE, MD

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location FREDERICK RD

18 (a) Funeral director JOHN F. DOWNS, INC.
(b) Address 715 LIGHT ST -30

19 OCT 4 - 1948 (Date rec'd by registrar) Washington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 19 48 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24- 19 48 to 9-30- 19 48, and that I last saw him alive on 9-30- 19 48

Immediate cause of death Carcinoma of bile ducts — Duration 1-2 yr ?

Due to

Due to

Other Conditions HAC vs C failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: on abse

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Welsh
Address BCH Date signed 10-1-48

VS 159

G67321

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 HARFORD RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EMILY D. EVANS (EMILY DIVER EVANS)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NO

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: RALPH EVANS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 14, 1890

8. AGE: Years 58 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name WILLIAM DIVER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY
15. Birthplace MARYLAND

16 (a) Informant HUSBAND
(b) Address SAME AS DECEASED

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

1948 OCT 4 - [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 SEPT 1948 at 7 15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 28 SEPT 1948 to 30 SEPT 1948. and that I last saw her alive on 30 SEPT 1948.

Immediate cause of death: CARDIO RESPIRATORY FAILURE
Due to: CEREBRAL HEMORRHAGE
Due to
Other Conditions

Duration: 4 HOURS; 2½ DAYS

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald L. England M D
Address MARYLAND GEN HOSP. Date signed 30 SEPT 48

VS 159

3c. C 19440

667322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667322 Registered No. 1940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 East Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Ishel Bush (Leroy Josiah Bush)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1945

8. AGE: Years 3 | Months 7 | Days 12 | If less than one day hr. min.

9 Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Rayfield Bush
13. Birthplace Dallas, Texas

MOTHER
14. Maiden Name Martha Griggs
15. Birthplace Georgia

16 (a) Informant Rayfield Bush
(b) Address 1627 E. Preston St.

17 (a) Burial (b) Date thereof Oct 4, 1948
(Burial, cremation, or removal) (month, day, year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Young
(b) Address 12[illegible] Pennsylvania Ave.

19 (a) OCT 4 - 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 4.03 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Fractured femur
Due to
Other Conditions Multiple wounds on head - burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-1-48 at approx. 3.45 p. M.
(b) Where did injury occur? Preston St. & Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury pedestrian struck by truck

23. Signature Howard J. Mulder M.D.
Medical Examiner
Date signed October 2, 1948

VS 151

667323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. 667323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Fayette St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mr Frank Wiesner Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 210932250

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1912

8. AGE: Years	Months	Days	If less than one day
36	3		hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business

FATHER
12. Name Stanislaw
13. Birthplace Poland

MOTHER
14. Maiden Name Veronica Kopsowski
15. Birthplace Poland

16 (a) Informant Bernard Wiesner
(b) Address 315 S. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazgenski
(b) Address 1930 Eastern Ave

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-48 19 . at 3:14 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-48 19 . to 10-2 1948, and that I last saw h[illegible] alive on 10-2-48 19 .

Immediate cause of death	Duration
Respiratory failure -	
Due to Haemorrhage	
Due to Oesophageal Varices	
Due to Portal Cerrhosis	
Other Conditions Due to Chronic Alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Hahn M.D.
Address University Hosp Date signed 10-2-48 M. D.

×

G673324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 R

G673324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 S. Bethel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, limits, write RURAL and give town)
(d) Street No. 134 S. Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Regina Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1908

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Driver
11. Industry or business

FATHER
12. Name Seward Washington
13. Birthplace St Marys Co. Md

MOTHER
14. Maiden Name Alice Cannon
15. Birthplace Wilmington Del.

16 (a) Informant Regina Washington
(b) Address 134 S. Bethel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Blanton St

19 OCT 4 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948, at 1145 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Sept 30 1948, and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death	Duration
Acute Pulmonary tuberculosis	6 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Bennett M. D.
Address 171 Asquith St Date signed 10-2-48

VS 150

67528 sl 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

Registered No. 67525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town 1616 Harlem Ave. Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Goldie Towell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 8-29-79

8. AGE: Years	Months	Days	If less than one day
69	1	3	..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Miles Towell
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda ?
15. Birthplace N.C.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Beatty Ave Huntington Park Lanham, Md

19 (a) OCT 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1948 at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 10-1 1948 and that I last saw him alive on 10-1 1948.

Immediate cause of death	peripheral vascular collapse	
Due to	gastro-enteric dilatation	
Due to	Recurrent enteritis	
Other Conditions	Renal insufficiency uremia	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify yes or no)
(e) Means of injury .....

23. Signature William O. Winternitz M.D.
Address Johns Hopkins Hospital Signed 10-2-48

VS 150

667326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667326

15-1139 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-08

8. AGE: Years	Months	Days	If less than one day
40	8	-	hr. min.

9. Birthplace Va (Town, county and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joe Venable
13. Birthplace Va.

MOTHER
14. Maiden Name Ann Thorn
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn Md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Rhantty ave

19 (a) Oct 4 - 1948 (b) Huntington for Baltimore, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 12 AM 40

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1948 to 10-2- 1948. and that I last saw h[illegible] alive on 10-2- 1948.

	Duration
Immediate cause of death Subphrenic abscess and Empyema thoracis	10 (?)
Due to Generalized peritonitis	14
Due to Perforated Appendix	21 (?)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation September 17, 1948
Major findings of operation: Appendiceal abscess; generalized peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature David C. Sassiston, Jr. M.
Address John Hopkins Hosp Date signed 10/3/48

VS 150

G673327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G673327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bradbery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Widow

6 (b) Name of husband or wife Edward (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 2, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	29	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Eleanor Mc Nutt
(b) Address 837 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Joseph b. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1948, at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/ 1948 to 10/1 1948, and that I last saw her alive on 10/1 1948.

Immediate cause of death Bronchopneumonia — Duration 4 W

Due to Myocarditis

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lapford MD
Address 837 N. Central Ave Date signed 10/4/48 M.D.

BC-48-00012 ✓ 667328

667328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. 667328

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 109 N. Carrollton Aves (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerald Keys ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1948.

8. AGE: Years — Months 8 Days — If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leroy Keys.

13. Birthplace Philadelphia, Penna.

MOTHER 14. Maiden Name Inez Brown.

15 Birthplace Sumter, S. C.

16 (a) Informant Inez Keys.

(b) Address 109 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Wm. Fisher R. Williams

(b) Address 322 N. Johnson St. Huntingtor Indiana, Ind.

19 OCT 4 - 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1948 at 11 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 9-30 1948. and that I last saw h/m alive on 9-30 1948

Immediate cause of death Respiratory failure

Due to Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. J. Friedrich Jr. M. D.

Address Univ. Hosp. Date signed 10-1-48

VS 150

X

667529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 667529

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 3104 Foster Avenue
(c) Hospital or institution:
S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KRASKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Elizabeth Kraska

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1891

8. AGE: Years: 57 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: ?
13. Birthplace

MOTHER
14. Maiden Name: ?
15. Birthplace

16 (a) Informant: George Kraska
(b) Address: 3104 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1948 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd

18 (a) Funeral director: John J. Duda
(b) Address: 2669 Hudson St

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subinski M.D. Medical Examiner.
Date signed 10-2-48

VS 151

667330

667330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D. 21.
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 152 Bradley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MASSCELINE Marceline Savage

Carpenter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex C | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1902

8. AGE: Years 46 | Months 5 | Days 11 | If less than one day hr. min.

D.J.M.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Savage
13. Birthplace Virginia

MOTHER
14. Maiden Name Mildred ?
15. Birthplace 933 Shilds Place

16 (a) Informant Henry Carpenter
(b) Address 933 Shilds Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (mo.) (day) (yr.)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A.A. HALSTEAD
(b) Address 918 Druid Hill Avenue

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. REGISTRAR

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1948 at 1:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Schmidt M.D.
Medical Examiner.
Date signed 10/3/48

2331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G673531

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 E. 23rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 E. 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARISSA MAY MUTH

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23, 1896

8. AGE: Years: 52 Months: 4 Days: 9 If less than one day: hr. min

9. Birthplace: Sparks, Md. (Balto. Co.) (Town, county, and state)

10. Usual Occupation: School Teacher

11. Industry or business:

FATHER
12. Name: George R. Muth
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Sarah R. Tracey
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Esther E. Hamel
(b) Address: 5109 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory: Bosley's Cem.
Location: Sparks, Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Kuntzler for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 7:04 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1948 to Oct 2 1948 and that I last saw her alive on Sept 30 1948

Immediate cause of death: Coronary Thrombosis — Duration: four months

Due to: Myocardial Weakness — 5-6 yrs.

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Polk II M. D.
Address 2431 Maryland Ave Balto 18, Md. Date signed Oct 4 48

X

67332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 667332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 E 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 27th St.; (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Ann Adams

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife John J Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1889

8. AGE: Years 59 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace Balto Co. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Matthew Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Kennedy
15. Birthplace Ireland

16 (a) Informant Mr John J Adams
(b) Address 313 E 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Funeral Home
Location

18 (a) Funeral director J. J. Adams & Sons
(b) Address 1618 Light St

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/48 19 at 1A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1/ 1948, to 10/2/48, and that I last saw her alive on 10/2/48.

Immediate cause of death: cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm B Seale M.D.
Address 517 Medical Arts Date signed 10/3/48

VS 50

67333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 67333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Don't
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. Apt #166 Northwood Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Vernon Caneva

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-09-9764

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gladys Caneva

6 (c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Oct. 9 - 1904

8. AGE: Years: 43 | Months: 11 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Factory Superintendent

11. Industry or business: U.S. Printing & Lithograph

FATHER
12. Name: Clarence Caneva
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Marie Ross
15. Birthplace: Germany

16 (a) Informant: Mrs. Gladys Caneva
(b) Address: #319 Marble Hall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/48 (month, day, year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: Krause Funeral Home
(b) Address: 1216 E. Chase St. Huntington Building, Md.

19 (a) OCT 4 1948 (b) Registrar
(Corrected by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/1 1948, at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: C. P. Tulenko M.D. Medical Examiner.
Date signed: 10/1/48

VS 151

G67334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G67334
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 320 N. Monroe St. Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Sulka

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-8731

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Anna Sulka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28 -1888

8. AGE: Years	Months	Days	If less than one day
60 Yrs.	6	5	hr. min.

9. Birthplace Czechoslovakia --Brunn
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Albert F. Goetze Co.

FATHER
12. Name James Sulka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Anna Sulka (wife)
(b) Address 320 N. Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5/48 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE..17

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Oct 2, 1948
and that I last saw h... alive on Oct 2 1948

Immediate cause of death Acute Pulmonary Edema.
Duration 1 day

Due to Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature Louis Dyson M.D.
Address 876 Wilkens Ave Date signed 10/2/48

VS 159

667335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 667335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 8d ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 8d ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD H. BEEFELT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6. (b) Name of ~~husband or~~ wife Late BARBARA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 26 1871

8. AGE: Years	Months	Days	If less than one day
77	2	7	hr. min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name EDWARD D
13. Birthplace MD.

MOTHER
14. Maiden Name ROSE —
15. Birthplace MD.

16 (a) Informant MRS CARRIE DAVIS
(b) Address 4019 8d ST

17 (a) BURIAL (b) Date thereof OCT 6 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMONDSON AVE + LONGWOOD

18 (a) Funeral director Henry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) OCT 4 1948 (Signature of Registrar)
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 3 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 3 1948.
and that I last saw him alive on Oct 2 1948.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to hypertensive cardio	
Due to vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip W. Kreuter M.D.
Address 302 Latrobe Date signed 10/4/48

Philip W. Kreuter

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G673336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G673336

Leh 122408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2934 Greenmount Avenue 18 (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME George Beldovitz ALSO Name As (George A Belle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/10

8. AGE: Years 38 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George
13. Birthplace Europe

MOTHER
14. Maiden Name Anna Kawaski
15. Birthplace Md.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer.
Location Balto Md

18 (a) Funeral director C. Vernon Lemmon
(b) Address 461 Park Heights Huntington Williams, Md

19 OCT 4 1948 (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25/48 to 10/1/48.
and that I last saw him alive on 10/1/48

Immediate cause of death

Due to Pulm + be

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: ? yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton, M.D.
Address Baltimore City Hospitals Date signed 10/4/48

VS 150

G67337

AB-119565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67337 Registered No. 1110a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Druery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary (nee Holston)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 8- 1910

8. AGE: Years	Months	Days	If less than one day
~~yrs~~ 38	1		hr. min.

9. Birthplace Md. Baltimore, Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business Crown Cork & Seal Co.,

FATHER
12. Name Otto Druery (D
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha Gould (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30- 1948 at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9- 1948 to 9-30- 1948, and that I last saw him alive on 9-30- 1948.

Immediate cause of death Bronchopneumonia
Bronchiectasis, bilateral
Purulent empyema on rt.
Due to Clinical Evidence
amyloidosis.
Due to
Other Conditions Old tuberculosis
? active
(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

Duration ? years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Marine
Address 4940 Eastern Ave Date signed 10-2-48 M. D.

VS 150

Please write the causes of death clearly and legibly. Physicians: Especially important. Please answer all questions carefully supplied. Use

G67338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67338

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Accuracy of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER E. WERTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-2669

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Barbara Wertz
6 (c) If alive, give age 9 years

7. Birth date of deceased (mo., day, yr.) June 21 1880

8. AGE: Years	Months	Days	If less than one day
68	3	12	hr. min.

9. Birthplace Alexia Md
(Town, county and state)
10. Usual Occupation Retired Route Driver
11. Industry or business Rice Bakery

FATHER
12. Name John Wertz
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name — Hoffacker
15. Birthplace Carroll Co Md

16 (a) Informant Donald E Wertz
(b) Address 5258 Reisterstown Road

17 (a) Burial (b) Date thereof Oct 6 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry H Armacost
(b) Address 4918 Ridgewood Ave

19 (a) OCT 4 - 1948 (b) Huntington Hollins, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 5 40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948 to 10/3 1948
and that I last saw h in alive on 10/3 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Embolization from Fibrillating Auricle	
Due to Arteriosclerotic & Hypertensive Heart Disease	
Other Conditions Splenic Infarct	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald E Wertz M.D.
Address Sinai Hospital Date signed 10/3/48

VS 150

667339 ✓ 667339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days) 58y 8m 9d

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 GORSUCH AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE EDNA KING (Anna Eva King)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Stephen Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JAN. 23, 1890

8. AGE: Years 58 | Months 8 | Days 9 | If less than one day 10 hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business AT HOME

FATHER
12. Name Peter Grossman
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Anna E Grau
15. Birthplace Balto. Md

16 (a) Informant Stephen Leo King
(b) Address 1732 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore National
Location 5300 Frederick Rd.

18 (a) Funeral director J. Walter Conklin
(b) Address 1448 Gorsuch Ave

19 (a) Filed OCT 4 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL ~~CERTIFICATION~~

20. DATE OF DEATH Oct. 2, 1948, at 4.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948 to Oct. 2, 1948, and that I last saw her alive on October 1, 1948

Immediate cause of death Respiratory Failure — Duration

Due to Cardiac Insufficiency

Due to Hypertensive Cardiovascular Disease.

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congestive Heart Failure

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hosp. Date signed 10-2-48

937

VS 153

667340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

667340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 North Durham St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOSEPH BURNS

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1924

8. AGE: Years 23 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business Baltimore City

FATHER
12. Name Thomas J. Burns
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Mes[illegible]ll
15. Birthplace Baltimore, Md.

16 (a) Informant: Mrs. Margaret Burns Saul
(b) Address 1519 Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5th, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 12[05] PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture skull with
[illegible] of brain tissue.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/4
(a) Date of injury 10-1-48 at approx. 9.20 a. M.
(b) Where did injury occur? Erdman Ave. & North Pt. Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Motorcycle and truck collision

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed October 1, 1948

X

667341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Clarendon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Veise (WILLIAM FERGUSON VEISE)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mayfield W. Veise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1880

8. AGE: Years 68 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business

FATHER
12. Name John Veise
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ferguson
15. Birthplace Baltimore, Md.

16 (a) Informant: Mr. John J. Veise
(b) Address 17 Carendon Ave., Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible] Washington Williams, Jr. (Signature of informant)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 8:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fulmer M.D.
Medical Examiner.
Date signed 10/7/48

Oal-6667342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667342

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kresina
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married

6 (b) Name of husband or wife Nana
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-03

8. AGE: Years	Months	Days	If less than one day
44	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Nana
11. Industry or business

FATHER
12. Name Frank Kresinsa
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 7 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31, Md.

19 (a) [illegible] (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 9 14 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948, to 10-2 1948, and that I last saw him alive on 10-2 1948.

immediate cause of death Multiple pulmonary infarcts & Congestive Heart failure

Due to Rheumatic Heart disease - inactive & mitral stenosis & mitral insufficiency & auricular fibrillation

Other Conditions Syphilis - late treated

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature [illegible] Jackson

Address The Johns Hopkins Hosp. Date signed 10/3/48

VS 392

write the causes of death clearly and legibly.

9213

667343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Virginia (b) County
(c) City or town Berkley Springs, W. Va. (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Belle Merica

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 17 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Berkley Springs, W. Va. (Town, county, and state)

10. Usual Occupation student

11. Industry or business

MOTHER / FATHER
12. Name Herbert Merica
13. Birthplace St. John Run, W. Va
14. Maiden Name Helen Miller
15. Birthplace Berkley Springs, W. Va.

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd, Balto. 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 48 (month) (day) (year)
(c) Cemetery or crematory Greenway
Location Berkeley Springs W. Va

18 (a) Funeral director Funeral Home
(b) Address Pikesville, Maryland.

19 (a) (Date received by registrar) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-48 19..., to 10-3-48 19..., and that I last saw her alive on 10-3 1948.

Immediate cause of death
Peritonitis effusion
Due to Acute Rheumatic
Due to Pancarditis

Duration 12 Days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy Pancarditis Rheumatic

PHYSICIAN
Underline the cause to which death should be directed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall P. Shugert M. D.
Address 326 Madison Ave Huntington, W. Va. Date signed

VS 150

G67344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G67344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4615 Mannasota Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annabelle C. Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/83

8. AGE: Years	Months	Days	If less than one day
65	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Howard Meeks
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lydia Ringgold
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mildred Altenburg
(b) Address 4615 Mannasota Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1948 (month) (day) (year)
(c) Cemetery or crematory Westview Park
Location Baltimore Md

18 (a) Funeral director John C. Moran
(b) Address 3600 E. Baltimore St

19 (a) [illegible] (b) [illegible]
(Date received by registrar) (Registrar)

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 3 1948 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to 10/3 1948 and that I last saw her alive on 10/3 1948

Immediate cause of death UREMIA — Duration

Due to Lowered plasma proteins, liver damage

Due to Obstructive jaundice, stone in common duct

Other Conditions Cholecystetis with cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation 9/23/48

Major findings of operation: Acute cholecystitis, dilated common duct

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hosp. Date signed 10/3/48

GR-48-21138

667345

667345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Cutonsville - 28, - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Delroy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy. Kron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/4/48

8. AGE: Years | Months | Days 1 | If less than one day 25 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stephen Joseph Kron
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elfrede Gadau
15. Birthplace Germany

16 (a) Informant Stephen J. Kron.
(b) Address 1 Delroy ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Mary Catherdale
Location Baltimore Md

18 (a) Funeral director Edgar Martin
(b) Address Catonsville Md

19 (a) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/48 19 12:10A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948. to 10/4 1948. and that I last saw h alive on 10/3 1948.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Strohler M. D.
Address Bon Secours Hosp Date signed 10/4/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 42a

Registered No. 667346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Blanche Estelle Small

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph S. Small
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 17, 1888

8. AGE: Years	Months	Days	If less than one day
60	8	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Nathan Sewell
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan R. Hickey
15. Birthplace Virginia

16 (a) Informant Joseph S. Small
(b) Address 6004 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

OCT 4 - 1948 (Date rec'd by Registrar) (b) Lexington Mausoleum

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948 at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 2 1948 and that I last saw h[illegible] alive on Oct 2 1948

Immediate cause of death — Duration
cerebro vascular accident

Due to hemorrhage into temporal and parietal lobes, left

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Judith S. Landau M. D.

Address Date signed

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

667347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. 667347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2879 Chesterfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2879 Chesterfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOLORES MARION BARNES

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213-26-9730

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1930

8. AGE: Years 18 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk - Vacation Time

11. Industry or business Stewarts

FATHER
12. Name Martin J. Barnes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances A. Simmons
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Frances A. Barnes
(b) Address 2879 Chesterfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 4 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to Oct 2 1948.
and that I last saw h[illegible] alive on Sept Oct 2 1948.

Immediate cause of death: Pernicious Anemia and Tuberculosis — Duration:
Due to T. Tuberculosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin L. Ward M. D.
Address 823 Cathedral St Date signed Oct 4 48

VS 153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667348

667348

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Phil. Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Chestnut St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME ROBERT GRANGE HOLDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Marie McDonald Holden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	21	10 hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Marine Captain
11. Industry or business

FATHER
12. Name George C. Holden
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Middleton Holden
15. Birthplace Unknown

16 (a) Informant Marie McDonald Holden
(b) Address 3640 Chestnut St. Phila. Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Davids, Pa.
Location Pennsylvania

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1948, at 12:30 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hematoma, right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at Approx. 2 A. M.
(b) Where did injury occur? Found lying in doorway at Balderson & South Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury: Slipped and Fell to Ground

23. Signature Medical Examiner. M.D.
Date signed 10/4/48

VS 151

667349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A. Co.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred H. Kutter
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-09-9660

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Lena C Kutter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) May 3 -
8. AGE: Years 64 | Months 5 | Days - | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Reinhold Kutter
13. Birthplace Ger

MOTHER
14. Maiden Name Marie Winkler
15. Birthplace Germany

16 (a) Informant Lena C Kutter
(b) Address Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash Blvd

18 (a) Funeral director Uhlenhuth Funeral Home
(b) Address 3[illegible] & Orleans St

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 3 - 1948 at 3 56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25, 1948 to Oct 3, 1948 and that I last saw him alive on Oct 3, 1948.

Immediate cause of death: Lobar pneumonia — Duration
Due to Pulmonary and Splenic infarction
Due to Cardiac decompensation
Due to Hypertensive cardiovascular Disease
Other Conditions (1) Auricular fibrillation
(2) Mural thrombus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) ; While at work?
(e) Means of injury

23. Signature William T. Hearn, M.D.
Address Sou. Balti Gen Hosp Date signed
Baltimore 20, Md 10-3-48

VS 150

667350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121 R

667350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 267 Ballon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Durkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	w.	

6 (b) Name of husband or wife Anthony Durkin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1905

8. AGE: Years	Months	Days	If less than one day
43	4	25	hr. 9 min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Daniel Hunt
13. Birthplace N. C.

MOTHER
14. Maiden Name Etta Gantter
15. Birthplace N. C.

16 (a) Informant husband
(b) Address 267 Ballon.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5-48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John K Ramp
(b) Address Edmondson Ave, Md.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948, to 10-3 1948, and that I last saw her alive on 10-3 1948.

Immediate cause of death Uremic coma — Duration 4 da.

Due to Chronic glomerular nephritis

Due to

Other Conditions Hypertensive C.V. disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp. Date signed 10-3-48

X

667351 ✓ 667351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4813

Registered No.

667351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Eastern ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna (Wawrowicz) Jelski

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 3 00

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married.

6 (b) Name of husband or wife Joseph Jelski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Vincent Wawrowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Zofia ?
15. Birthplace Poland

16 (a) Informant Mr. Joseph Jelski
(b) Address 2203 Eastern ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Wetzel
(b) Address 421 S. Chester Street

19 (a) 1948 (Date filed by registrar) Washington Williams M.D. Registrar

20. DATE OF DEATH October 1 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1948 to Oct 1, 1948. and that I last saw h[er] alive on Oct 1 1948.

Immediate cause of death — Hypostatic Pneumonia — Duration Sept 28-48

Due to Carcinoma of Uterus — Aug. 1948

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rosario M.D.
Address 901 Kenwood Ave Date signed Oct 6 48

VS 3

X

G67352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne
(c) City or town Centerville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeremiah Kennedy
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-2-79
8. AGE: Years 69 Months 2 Days 2 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Farm Labor
11. Industry or business
FATHER 12. Name David Kennedy
13. Birthplace Md.
MOTHER 14. Maiden Name Healer ?
15. Birthplace Md
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 7-48 (month) (day) (year)
(c) Cemetery or crematory Burnside Md
Location Near Centerville
18 (a) Funeral director Edgar L. Lamb
(b) Address Centreville Md
19 (a) 1948 (Certificate rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 15A

20. DATE OF DEATH October 4 1948 at 8 M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 10/4 1948 and that I last saw him alive on 10/4 1948
Immediate cause of death Cancer of Prostate
Due to Kidd
Due to with
Other Conditions metastases (Include pregnancy within 3 months of death)
Date of operation 9/18/48
Major findings of operation: Ca of Prostate
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature H. S. Silver M.D.
Address J. H. H. Date signed 4 Oct.

VS 150

G67353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G67353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 N. Calvert Street
(c) Hospital or institution: 12 + 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 N. Calvert Street (if rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edmond Boone Luckett

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Margie A. Luckett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	15	hr. min.

9. Birthplace Hancock, Maryland (Town, county, and state)
10. Usual Occupation President - Retired
11. Industry or business Luckett Brickler Co.

FATHER
12. Name John R. B. Luckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Hall
15 Birthplace

16 (a) Informant Mrs. Margie Luckett
(b) Address 2315 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 - (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Date rec'd by Registrar) OCT 5 - 1948 Filed Washington Indiana M.D. (Signature and title of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1948 to Oct 2 1948 and that I last saw h[illegible] alive on Oct 2 1948

Immediate cause of death	Duration
Bronchial Pneumonia	4 da
Due to	
Due to Arteriosclerosis	4 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edw. Talbert M. D.
Address 2723 St Paul Date signed 10/4/48

VS 150

73-46 LH 2.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 667354
Registered No.

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Arnold
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 3, 1948

8. AGE: Years | Months | Days | If less than one day 16 hr. 25 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alister C. Anderson
13. Birthplace

MOTHER
14. Maiden Name Frances Hutchins
15 Birthplace Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Asbury Church Cem.
Location Barstow, Calvert Co. Md.

18 (a) Funeral director John O. Mitchell Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1948, at 5.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 3 1948, to October 3 1948, and that I last saw her alive on October 3 1948.

Immediate cause of death: Respiratory Failure — Duration: 17 hr

Due to: Atelectasis

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~operation~~ autopsy: Pulmonary atelectasis, edema, hemorrhage & of autopsy: G-I hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Harrison Clarke Spencer M.D.
Address Johns Hopkins Hosp Date signed 10-4-48

VS 15)

Physicians: please write the causes of death clearly and legibly. Cause of death must be certified.

673355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

673355 Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hr. 5min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 St. Anns Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: KATHERINE M. PAUL

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1908

8. AGE: Years 40 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin E Choffman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maud F. Freree
15. Birthplace Garrett Co., Md.

16 (a) Informant Benjamin F. Choffman
(b) Address 605 St. Anns Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Belto., Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Millicent, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948 at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Hemorrhage due to compound fracture of tibia

Due to (b) Fracture of Pelvis & Lacerations of scalp.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 3/48 7:30 P.M.
(b) Where did injury occur? 25th St. & Guilford Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Hit and Run

23. Signature Emil Vogt M.D. Medical Examiner.
Date signed 10/4/48

VS 151

67356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 67356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Grundy St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carmella Mosca — Carmela Mosca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francesco Or Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 4 1889

8. AGE: Years 58 | Months 9 10 | Days - | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sebastian Stile
13. Birthplace Italy

MOTHER
14. Maiden Name Consilia Casgona
15. Birthplace Italy

16 (a) Informant Frank Mosca
(b) Address 225 S. Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Frank Pelligrino
(b) Address 322 S. Highland Ave.

19 (a) OCT 5 1948 (Date received by registrar) (b) Huntington Ave, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1948, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948, to 10-4 1948, and that I last saw her alive on 10-4 1948.

Immediate cause of death: Hypertensive Cardiovascular Disease.
Due to Pos Cerebral Hemorrhage
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 10-4-48.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. 167557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Dora Terrace
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Dora Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Wittmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Wittmer

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Jan 17th 1869

8. AGE: Years 79 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name John Kiegel
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Birth
15. Birthplace Germany

16 (a) Informant Henry Wittmer
(b) Address 3021 Dora Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7th (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Allison Funeral Home
(b) Address 2008 Arlington Ave

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1948, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Oct. 4 1948 and that I last saw her alive on Oct. 1 1948.

Immediate cause of death Uremia — Duration

Due to Catheterization C.V.R.D.

Due to Marked arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Henry Haas M.D.

Address 4212 Boyd Rd Date signed 10/4/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be correctly supplied.

7358 JL-115686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667358 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Brunt St. -17 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Elizabeth Hawkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John Thomas Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1913

8. AGE: Years	Months	Days	If less than one day
35	-	6	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roscoe Latimore
13. Birthplace S. C.

MOTHER
14. Maiden Name Irene Warnick
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Va Brookes
(b) Address 1463 N. Carey St.
19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1948 at 11.50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 5 1947 to Sept. 25 1948. and that I last saw her alive on Sept. 25 1948.

Immediate cause of death	Duration
Due to Pulmonary tbc	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature L Gayle Burton M. D.
Address Baltimore City Hospitals Date signed 10/2/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) N/A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 703 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Montgomery (Thomas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1-48

8. AGE: Years | Months | Days: / | If less than one day: hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clarence Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Montgomery
15. Birthplace Sumter, S.C.

16 (a) Informant Helen Montgomery
(b) Address 703 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director James A. Stayton
(b) Address 142 Wolfe St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 1948 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Congenital atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 3 Oct 48

VS 151

7360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fourth St. & Chesapeake Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6207 Overall Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH W. STUMPFEL mp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1916

8. AGE: Years	Months	Days	If less than one day
32	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Stumpfel
13. Birthplace Austria

MOTHER
14. Maiden Name Emilie G. Quasney
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emilie G. Quasney
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Registered Twattington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 2.15pM

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Drowning

Due to

Other Conditions Simple Schizophrenia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at found 2.15 p. M.
(b) Where did injury occur? Arundel Cove
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Drowning

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed October 4, 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos. or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Milford Ave #7 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Schaunloeffel (Gertrude G. Schaunloeffel)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife C. Edward [illegible]aunloeffel

6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) March 28, 1885

8. AGE: Years 63 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Weaver
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Althea S. Eichert
(b) Address 2206 - 78th St., Jackson Hgts, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral Director Gilles & Amoran
(b) Address 4510 Liberty Heights Ave.

OCT 5 - 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 445 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 10/3 1948 and that I last saw her alive on 10/3 1948

	Duration
Immediate cause of death: Cardio-respiratory failure	1 day
Due to: Uremia	5 days
Due to: Hypertensive C-V Renal Disease	12 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann

Address Maryland General Hosp. Date signed M 10 D 3/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67362

G67362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2230 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALLEN H. KERNGOOD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie Kerngood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1888.

8. AGE: Years	Months	Days	If less than one day
59	10	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Mnfgr's Agent.
11. Industry or business

FATHER
12. Name Herman Kerngood,
13. Birthplace Germany.

MOTHER
14. Maiden Name Mollie Mansbach,
15. Birthplace Germany.

16 (a) Informant Mrs. Bessie Kerngood,
(b) Address 2230 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Lemmelman Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Washington Blvd. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-4 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to 10/4 1948, and that I last saw h alive on Sept-29 1948.

Immediate cause of death Coronary Thrombosis — Duration 5 minutes

Due to Arteriosclerosis — Duration 1 year

Due to Cerebro-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Gardiner M. D.
Address 2117 SOUTH RD. Date signed 10/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4602 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: HUNTER H. MOSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amy Carr

6 (c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): July 14, 1906

8. AGE: Years: 42 | Months: 2 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Parkersburg W. Va. (Town, county, and state)

10. Usual Occupation: Lawyer

11. Industry or business

FATHER
12. Name: Hunter H. Moss
13. Birthplace: Parkersburg W. Va.

MOTHER
14. Maiden Name: Anna Ambler
15. Birthplace: Winchester, Va.

16 (a) Informant: Ambler H. Moss
(b) Address: Brooklandville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Henry W. Jenkins, & Sons
(b) Address: York Rd. & Rossiter Ave.

19 (a) OCT 5 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3, 1948, at 11:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Barbiturate poisoning (nembutal)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: Oct. 1/48 at M.
(b) Where did injury occur? Lord Baltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
(d) Means of injury: Ingestion of sleeping pills

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed: 10/4/48

G67364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67364

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address At Sea
(c) Hospital or institution:
Sent to Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Charlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 Ashley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME CHARLES B. FERGUSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-14-1674

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Leila Ferguson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1900

8. AGE: Years	Months	Days	If less than one day
48	0	4	hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation Merchant Mariner

11. Industry or business Pan American Petroleum Transport Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Capt. L. C. McKay
(b) Address 122 E. 42nd St., N.Y.City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location Charleston, S.C.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at ? M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rigler M.D. (Medical Examiner)
Date signed October 4, 1948

G67365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G673365

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division STREET
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) h.f.c.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6. E. Hamilton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELENA BROWNE HEARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Charence Brown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) January 17, 1870

8. AGE: Years	Months	Days	If less than 1 day
78	8	16	hr min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Seneniat Brown
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mahaly PETERS
15. Birthplace Baltimore, Md.

16 (a) Informant Harold Heard.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 OCT 5 - 1948 (Date rec'd by registrar) (b) Filed Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 2ND 1948 at 4:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1948 to OCT 2nd 1948. and that I last saw h[illegible] alive on OCT 1st 1948

Immediate cause of death Renal failure - Uremia — Duration 3 weeks

Due to Hypertensive Cardio-renal disease — Duration 24 yrs.

Due to

Other Conditions Congestive failure.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W.M. Masserden Jr. M.D.
Address Provident Hospital Date signed 10-2-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 67306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Stanley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	11	19		

9. Birthplace Easton, Md. (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER — 12. Name	James Grace
FATHER — 13. Birthplace	Easton, Md.
MOTHER — 14. Maiden Name	Annie Moody
MOTHER — 15. Birthplace	Easton, Md.

16 (a) Informant Mrs. Margaret Byrd
(b) Address 1109 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lange & Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

10-1-1948

20. DATE OF DEATH 10-1— 1948. at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28— 1948. to 10-1— 1948. and that I last saw her alive on 9-30— 1948.

Immediate cause of death Chronic myocarditis — Duration

Due to

Due to

Other Conditions Congestive heart failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 10-4-48

VS 150

667367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 667367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace V. Jenkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife Arthur S. Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14-1901

8. AGE: Years	Months	Days	If less than one day
46	11	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Bayner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Baltimore Md.

16 (a) Informant Arthur S. Jenkins
(b) Address 1714 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/48 19 , at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from September 19 48 to Oct 2 19 48.
and that I last saw h[er] alive on 10/1/ 19 48.

Immediate cause of death

	Duration
Carcinoma of Stomach	1 year
Due to	
Due to	
Other Conditions Cachexia Abdominal Ascite (Include pregnancy within 3 months of death)	3 mo

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 1225 N Charles Date signed 10/3/48

VS 250

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67368

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME West Mobley

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9476

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	married

6 (b) Name of husband or wife Daisy Mobley
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
46				

9. Birthplace Chester Co. S. C.
(Town, county, and state)
10. Usual Occupation Truck man
11. Industry or business

FATHER
12. Name George Mobley
13. Birthplace Chester Co. S. C.

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Chester Co. S. C.

16 (a) Informant Daisy Mobley
(b) Address 420 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) OCT 5 1948 (Date rec'd by Registrar) (b) Funeral Home, Washington Blvd.

VS 150

Oct. 2-48 **MEDICAL CERTIFICATION** 556

20. DATE OF DEATH Oct. 2 1948, at 556 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Oct 2 1948.
and that I last saw h alive on Oct 1 1948

Immediate cause of death Congestive Heart failure — Duration 1 yr

Due to Hypertension Cardio Vascular Disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Cochran M. D.
Address 222 N. Caroline Date signed Oct 4 48

667369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 667369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Valley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Mary Widman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George H. Widman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1872

8. AGE: Years	Months	Days	If less than one day
76	7	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Thomas Bacher
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Hoban
15. Birthplace Ireland

16 (a) Informant Mr. George H. Widman
(b) Address 1019 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director Edgar W. Conklin
(b) Address 924 E. Eager St.

19 (a) Oct 5 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

DC

V 15 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1948 to 10-5 1948, and that I last saw h.er alive on 10-5 1948.

Immediate cause of death: Bronchopneumonia — Duration: 2 days
CERTIFICATION APPROVED BY
Due to
Due to Howard J. Madeira M.D.
CHIEF OR ASST. MEDICAL EXAMINER
Other Conditions: Fractured Rt. Hip — 4 weeks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence September 16 at ? P.M.
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury slipped and fell to floor

23. Signature [illegible] M. D.
Address 11 E. Chase St. Date signed 10-7-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

667370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667370 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2023 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age: 89 years

7. Birth date of deceased (mo., day, yr.): March 12, (1885)

8. AGE: Years: 58 | Months: 6 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: James Stanley
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Mary Cole
15. Birthplace: Maryland

16 (a) Informant: Elizabeth Stanley Evans
(b) Address: 1833 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/6/48 (month, day, year)
(c) Cemetery or crematory: Mt Auburn
Location: Md

18 (a) Funeral director: Edgar J. Nelson
(b) Address: 1303 Eastern Ave

19 (Date received by Registrar): OCT 5 1948 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/2 1948, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autop. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Chas. Schulenberg M.D. Medical Examiner.
Date signed: 10/3/48

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 657371

657371 SC 48, 8/630

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N. Castle St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Linnemen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stuart Linnemen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Jeannette Irene Simpson
15. Birthplace Severn, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location S. A. Med. School 11/30/48

18 (a) Funeral director
(b) Address

19 (a) 10/5/48 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1948 to Sept 13 1948. and that I last saw her alive on Sept 13 1948.

Immediate cause of death: Subarachnoid Hemorrhage — Duration

Due to Birth Injury?

Due to

Other Conditions Prematurity Incomplete Aeration of Lungs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in case of place)
(e) Means of injury

23. Signature S A Warren M.D.

Address Sinai Hospital Date signed Oct 4/48

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

167,572 BC-48-20620 ✓ 167,572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 167,572

161c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negroe	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27-48

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 22 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charlie Clarke
13. Birthplace North Carolina

MOTHER
14. Maiden Name Bessie Clarke
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) OCT 5 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from , 19 , to , 19 , and that I last saw h alive on , 19 .

Immediate cause of death: Asphyxia — Duration

Due to

Due to Intrapartum fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Brown M.D.
Address Date signed 10-8-48

67573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. 673573

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st Street

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 62 days

(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: -

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 3011 Pulaski Highway (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: PIORUNSKI, LEONARD JOSEPH

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No.: unk219-12-6305

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	m

6 (b) Name of husband or wife: RITA PIORUNSKI

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1924

8. AGE: Years	Months	Days	If less than one day
24	7	1	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER — 12. Name: Joseph Piorunski

13. Birthplace: Balto, Md.

MOTHER — 14. Maiden Name: Mary Glass

15. Birthplace: Balto, Md.

16 (a) Informant: Records

(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)

(c) Cemetery or crematory: Holy Rosary

Location: Baltimore

18 (a) Funeral director: Philip Henry Lee

(b) Address: 2024 Orleans St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Station, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3, 1948, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1948 to Oct. 3, 1948 and that I last saw him alive on October 3, 1948

Immediate cause of death: 1-Hodgkin's Disease — Duration: 3 years

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

Address: Clinical Director Date signed: Oct 4, 48 M. D.

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 53rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Diller Ave (If rural give location)
(e) Citizen of foreign country? — ~~Yes or~~ No) If yes, name country —

3 (a) FULL NAME: Mrs. Harry A. Felling (Catherine) CATHERINE ANN ELIZABETH FELLING

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry A. Felling

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 3, 1883

8. AGE: Years 65 | Months 6 | Days 0 | If less than one day — hr. — min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Charles L. Sims
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Lola Thomas
15. Birthplace: Maryland

16 (a) Informant: Mr. Harry A. Felling
(b) Address: 4201 Diller Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory: Jerusalem Church Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1948, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1948 to Oct. 3 1948 and that I last saw her alive on Oct. 3 1948.

Immediate cause of death: Cerebral embolus — Duration: 5 days

Due to: Mural Thrombi - heart — weeks

Due to: Arteriosclerotic heart disease — years

Other Conditions: multiple pulmonary emboli

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: M. R. Cox M.D.
Address: Union Memorial Hospital Date signed: 10-5-48

VS 15)

667375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667375

ES- 119381

47c

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 7010 Fait Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andy Hill (ANDREW HILL)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-3575

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Alma ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7, 1881

8. AGE: Years 67 | Months 0 | Days 28 25 | If less than one day hr. min.

9. Birthplace Finland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Henry Hill (Andrew Hill)

FATHER 13. Birthplace Finland

MOTHER 14. Maiden Name Ida Hill

MOTHER 15. Birthplace Finland

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2- 1948 at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2- 1948 to 10-2 1948, and that I last saw h im alive on 10*2 1948.

Immediate cause of death – BRONCHOGENIC CARCINOMA

Due to BRONCHIAL PNEUMONIA terminal

Due to ? Cerebral metastasis

Gangliglioblastoma cerebri

Other Conditions Sclerosis

Duration Months

(Include pregnancy within 3 months of death)

Date of operation —o

Major findings of operation: —o

of autopsy: ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Warren E Porter M.D.

Address Balto. City Hospitals Date signed 10/4/48

VS 130

X

667376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667376

3C-C28570 104a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EDWARD R. SOKAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1945

8. AGE: Years 3 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Edward Sokal
13 Birthplace Stuebenville, Ohio

MOTHER
14. Maiden Name Margaret Newschaffer
15. Birthplace Baltimore, Maryland

16 (a) Informant Margaret Sokal (mother)
(b) Address 1919 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Upper respiratory infection

Due to: acute dilatation of heart

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/2/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 67377

Please write clearly in ink. Use typewriter if possible. Do not use pencil. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Low Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CORA MILLS

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-1904

8. AGE: Years	Months	Days	If less than one day
44	1	28	hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant James Dorsey
(b) Address 1342 Mosher Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10-5-48 (month)
(c) Cemetery or crematory Balto. National Cemetery
Location Baltimore, Maryland

18 (a) Funeral director C. G. Cooper
(b) Address 512 N. Carrollton Avenue

19 (a) OCT 5 - 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Ryon M.D.
Medical Examiner.
Date signed 9-30-48

667378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667378 Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CRICKENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1911

8. AGE: Years	Months	Days	If less than one day
37	1	9	hr. min.

9. Birthplace Green County, Virginia (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Restaurant

FATHER
12. Name Robert Shipp
13. Birthplace Green County, Virginia

MOTHER
14. Maiden Name Ida Gorden
15. Birthplace Green County, Virginia

16 (a) Informant Floyd Shipp
(b) Address Rockesville, Virginia

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory
Location Rockesville, Va.

18 (a) Funeral director J. Carlton Clore by [illegible]
(b) Address Cabin John, Md.

19 (a) OCT 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 9.00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed October 2, 1948

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 667379

667379

Every item of information should be carefully supplied. Be sure that your answer is correct and legible. Physicians: please write the causes of death clearly and legibly. Fee $2.00

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3030 Baker St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3030 Baker St., (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Carroll W. Haines

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel M. Haines

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) August 20, 1885

8. AGE: Years	Months	Days	If less than one day
63 62	1	14	hr. min.

9. Birthplace Medford, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Railway Express, Inc.

FATHER

12. Name Ephriam Haines

13. Birthplace Md.

MOTHER

14. Maiden Name Martha Jane Cassell

15. Birthplace Md.

16 (a) Informant Mrs. Ethel M. Haines

(b) Address 3030 Baker St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-1948 (month) (day) (year)

(c) Cemetery or crematory Winter's Cemetery

Location Carroll Co., Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 11.00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 31 1948 to Oct. 4 1948. and that I last saw h[illegible] alive on Oct. 4 1948.

Immediate cause of death Coronary Thrombosis (2 attacks)

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration 8 mos

?

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Philip F. Lerner

Address 2401 N. North Ave. Date signed Oct. 6, 1948

VS 150

667380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667380

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Omission or inaccuracy should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Mount Inc, 3706 Nortonia Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Elizabeth Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Lewis A. Roth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1884

8. AGE: Years	Months	Days	If less than one day
64	4	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Matthew J. Finn
13. Birthplace Virginia

MOTHER
14. Maiden Name Elvira Clark
15. Birthplace Virginia

16 (a) Informant Lewis A. Roth
(b) Address 4209 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1948 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Maryland

18 (a) Funeral director Harry Weinraub
(b) Address 4204 Ridgewood Ave

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19— to Oct 5 1948.
and that I last saw her alive on Oct 5 1948.

Immediate cause of death Uremia, Heart failure — Duration

Due to Hypert. C. V. Disease Arteriosclerosis

Due to Arteriosclerosis

Other Conditions Cellulitis left leg front

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: /

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence / at M
(c) Where did injury occur? / (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? / (Specify type of place) While at work?
(e) Means of injury /

23. Signature [illegible] M. D.
Address Date signed Y/C 1948

VS 150

Kurt Levy

667381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

667381 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Lyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2220 Lyndhurst Ave (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertha O. Cohen (Bertha .O. Cohen)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1886

8. AGE: Years 62 | Months 2 | Days 23 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Levi Oppenheimer

13. Birthplace Germany

MOTHER 14. Maiden Name Rachael Stern

15. Birthplace Germany

16 (a) Informant [illegible] Weil

(b) Address 3821 Garrison Blvd

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/7/48 (month) (day) (year)

(c) Cemetery or crematory Henry Friedship Cem.

Location Baltimore County Md.

18 (a) Funeral director J. Epstein Co

(b) Address 1 E. Preston St

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 10.03 M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1941, to Oct. 5 1948, and that I last saw h alive on October 5 1948.

	Duration
Immediate cause of death: Coronary thrombosis	½ hr.
Due to: Chronic Hypertension	7 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Japeman Stamer

Address 3300 West North Ave Date signed 9/5/48 M. D.

VS 3

667382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667382

552

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyoming Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 G. St, SW, Washington, DC (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HODGE, CHARLES RODGER

3 (b) If veteran, name war WW 1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	w

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17, 1895

8. AGE: Years	Months	Days	If less than one day
53	7	16	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation machine operator

11. Industry or business U. S. Government

FATHER
12. Name Rodger Hodge
13. Birthplace Md

MOTHER
14. Maiden Name Lucy Maxfield
15. Birthplace Va

16 (a) Informant Record
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Arlington Hall
Location Arlington, Va

18 (a) Funeral director W. Bladt Sons & Co
(b) Address 1432 You St NW

19 (a) OCT 5 1948 Washington, D.C. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948 at 2:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1948 to Octo. 3, 1948 and that I last saw him alive on Oct. 3, 1948

Immediate cause of death 1-Osteogenic sarcoma of skull — Duration 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address Clinical Director Date signed 10-5-48

V S 150

Please write clearly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667383

Registered No. 1216

LCH 123509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Plantview (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME TONY PRIVITERA

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alice

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 12/28/19

8. AGE: Years 28 Months 9 Days 4 If less than one day hr. min

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Privitera (d)
13. Birthplace ?

MOTHER
14. Maiden Name Catherine ?
15. Birthplace

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director W. W. Chambers
(b) Address Washington D.C.

19 OCT 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/48 at 12:40 PM

21. I certify that death occurred on the date above stated that I attended deceased from 9/27/48 to 10/5/48 and that I last saw h 1m alive on 10/5/48

Immediate cause of death: Uremia — Duration 10 days

Due to: Chronic glomerulo-nephritis — Duration ?

Due to:

Other Conditions:
(Include pregnancy within 3 months of death.)

Date of operation:

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William P. Kuhland M.D.
Address Balto City Hosp Date signed 10/6/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67384

55c

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp Women Md
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL, and give town)
(d) Street No. 45 Penn Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME Gertrude Missoura Null

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan - 22 - 1877
8. AGE: Years 71 | Months 8 | Days 17 | If less than one day hr. min. 4

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Samuel Null
13. Birthplace Penn.

MOTHER
14. Maiden Name Hebbi Lippy
15. Birthplace Penn.

16 (a) Informant Mrs. J. D. Parker
(b) Address 3304 Alto Rd - Balto-16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1948 (month) (day) (year)
(c) Cemetery or crematory Knilers
Location Carroll Co

18 (a) Funeral director Jr Bankard - Son
(b) Address Westminster Md

19 (a) Date rec'd by Registrar OCT 6 1948 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 5 - 1948, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct - 5 - 1948, and that I last saw her alive on Oct - 5 - 1948.

Immediate cause of death	Duration
Pulmonary edema	
Due to Carcinoma of Thyroid	
Due to	
Other Conditions Pericarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Thyroid

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry H. Lederer M. D.
Address Hosp. Women Md. Date signed X - 6 - 48

667385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

667385 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Johns Hopkins Hosp.

(c) Hospital or institution: Hosp. Women. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2300 Callow St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME William Everett Scholz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Scholz

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Apr - 17 - 1882

8. AGE: Years 66 | Months 5 | Days 13 | If less than one day: hr. min. 17

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name ? Scholz

13. Birthplace Not known

MOTHER 14. Maiden Name Madeline ? Schultz

15. Birthplace Not known

16 (a) Informant Mildred Shr. McMullen

(b) Address 2300 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-27 (month) (day) (year)

(c) Cemetery or crematory Loreland Park

Location Balto Co. Md.

18 (a) Funeral director Wm Cooke Inc.

(b) Address 1211 St Paul St

19 OCT 6 1927 (Date received by registrar) (b) Huntington Maryland, M.D.

VS 150 11a

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 4 - 1927 at 2 15 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct - 4 - 1927, to Oct - 4 - 1927, and that I last saw h she alive on Oct - 4 - 1927.

Immediate cause of death	Duration
Cerebro Vascular Accident	
Due to Arteriosclerotic - Hypertensive Cardiovascular	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George H. Schlesinger M. D.

Address Hosp Wom. Md. Date signed X - 4 - 27

X

7386 Order 6
474392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67386

Registered No. 518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Frankstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Spidel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Clara Spidel
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) 1-23-81

8. AGE: Years 67 | Months 8 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name John Spidel
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Mattle
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 6 (month) (day) (year)
(c) Cemetery or crematory Spruce Grove
Location Altoona Pa.

18 (a) Funeral director Fulton Funeral Home
(b) Address 1901 6th Ave Altoona Pa.

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 7:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14-48 1948, to 10-5 1948, and that I last saw him alive on 10-5 1948

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Bleeding tendency & reduced platelets

Due to Pancytopenia - etiology undetermined

Other Conditions Probable Carcinoma of Prostate
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature D. Jackson
Address The Johns Hopkins Hosp Date signed 10/6/48

VS 150

667.587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

667387

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Baltov Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (Fine) Fein

MEDICAL CERTIFICATION

3 (b) If veteran, name war | 3 (c) Social Security Account No.

20. DATE OF DEATH 10/3 1948, at 8:20 A M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Elliott (Fine) Fein
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

16 (a) Informant Mr Abe Garron
(b) Address 904 Whitelock St

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1184-1186 W North Ave

19 (a) OCT 6 1948 (Date rec'd by registrar) (b) Huntington Woods, Mich.

23. Signature [illegible] M.D. Medical Examiner.
Date signed 10/4/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2664 LAURETTA AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2664 LAURETTA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country NO.

3 (a) FULL NAME MANSFIELD FERRELL

3 (b) If veteran, name war

3 (c) Social Security Account No. 283-10-2361

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife AGNES P. FARRELL
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. JAN 1. 1884

8. AGE: Years	Months	Days	If less than one day
64	9	3	hr. min.

9. Birthplace CHARLESTON W. VA. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business U.S.A.

FATHER
12. Name JOHN. FERRELL
13. Birthplace CHARLESTON W. VA.

MOTHER
14. Maiden Name KATHERINE BALL
15. Birthplace CHARLESTON W. VA.

16 (a) Informant AGNES P. FERRELL
(b) Address 2664 LAURETTA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 7-48 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL
Location BALTIMORE

18 (a) Funeral director JOHN. T. STANSBURY
(b) Address 2300 EDMONDSON AVE.

19 (a) OCT 6 1948 (b) [illegible]
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 4 1948, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 10-4 1948 and that I last saw h alive on 10-1-48 1948

Immediate cause of death Myocardial failure — Duration 1 Day
Due to coronary thrombosis — 3 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gary S. Lumbel M. D.
Address 2702 Edmondson Date signed 10-4-48

VS 150

X

667389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 667389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME PETER J. HUNT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Hunt

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) JUNE 20, 1881

8. AGE: Years 67 | Months 3 | Days 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: William J. Hunt
(b) Address: 308 Westshire Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7-48 (month, day, year)
(c) Cemetery or crematory: Holy Cross.
Location: A.A.Co

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 EDMONDSON AVE

OCT 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 2.10 PM

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to Hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at approx. 1.45 P. M.
(b) Where did injury occur? 3 S. Fulton St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Hose attached to gas pipe

23. Signature Emil L. Hoyer M.D. Medical Examiner.
Date signed 40 Oct

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 No Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Rudman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) If 84

8. AGE: Years 84 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Nathan Rudman
(b) Address: 1641 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory: Herzl Mt Carmel
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2426 Eastern Place

19 (c) OCT 6 - 1948 (Date rec'd by Registrar) (d) Huntington Pollitt, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948, at 10 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1948 to 10/5 1948, and that I last saw h im alive on 10/5 1948.

Immediate cause of death: Pulmonary Edema

Due to: Arteriosclerosis and Hypertensive Heart Dis.

Due to:

Other Conditions: Pneumonia and Pulmonary Contusions
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Above.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Irving Kepp M.D.
Address: Sinai Hosp. Date signed 10/5/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42E

G67391 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Rosier.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm Rosier.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 [illegible]7

8. AGE: Years	Months	Days	If less than one day
90 91	11	29	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Augustus C. Almony.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Eva Almony.
(b) Address 2704 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/48 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Balto. Co. Md.

18 (a) Funeral director Justice E. Sowers
(b) Address 3638 Roland Ave.

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Maryland

VS 150

MEDICAL CERTIFICATION

p.

20. DATE OF DEATH October 4, 1948, at 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Oct 4 1948, and that I last saw h[illegible] alive on Oct 2 1948. [illegible]

Immediate cause of death [illegible] Heart — Duration 1 hr.
Due to Coryza - Condition — 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. Foster M.D.
Address 2524 E. Pratt St. Date signed Oct 5-48

X

57392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G67392

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Annabel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rodella Lowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Guy K. Lowman

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) April 6, 1877

8. AGE: Years 71 | Months 5 | Days 27 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name: Samuel Newton
13. Birthplace: Md

MOTHER
14. Maiden Name: Mary E. Baldwin
15. Birthplace: Md

16 (a) Informant: Arthur Lowman
(b) Address: 424 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Annapolis Blvd

18 (a) Funeral director: John F. Denny Inc
(b) Address: 715 Eight St.

OCT 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams MD

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1948, to 10-3-1948, and that I last saw her alive on 10-3-1948.

Immediate cause of death: (1) Diabetes Mellitus — Duration

Due to

Due to

Other Conditions: Generalized Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature: William T. Haven, M.D.
Address: 500 Dolphin Ave Hosp Date signed
Baltimore 30, Md 10-3-48

correct age is especially important. Physicians: please write the causey of death clearly and legibly.

67393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67393

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GLAUM

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Glaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1881

8. AGE: Years 67 | Months 1 | Days 26 | If less than one day: hr. min.

9. Birthplace Owings Mills, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Glaum
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Norman Glaum
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem.
Location Garrison Forest, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 6 - 1948 (Date rec'd by Registrar) (b) Registrar Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1948 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Oct 4 1948 and that I last saw him alive on Oct 4, 1948

Immediate cause of death: Myocardial Infarct — Duration:

Due to: Acute Coronary Thrombosis

Due to: Arterio-Sclerotic Heart Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius C. Glaum M. D.
Address 5356 Reisterstown Rd Date signed 10/5/48

VS 150

If the correct age is especially important. Physicians: please write the causes of death clearly and legibly. They form of information should be carefully supplied. The

G67394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67394

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Shriner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Filbert

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth-date of deceased (mo., day, yr.) April 15, 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
87	5	20		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Filbert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Feldpush
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. G. McLaughlin
(b) Address 2204 Kentucky Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Ave. Balto.

19 (a) OCT 6 1948 (Date received by registrar) (b) ~~Huntington Williams, M.D.~~

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31st 48 to Oct 4th 1948 and that I last saw her alive on Oct 4th 1948

Immediate cause of death	Duration
Myocardial Insuffiency	1day
Due to Cardio renal vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. Nelson M.D.
Address 617 W. 40th St Date signed 10/6/48

VS 150

667395

A 65-831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

667395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin Wylie,
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3		hr. min

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name	Melvin & Carrol
	13. Birthplace	Va.
MOTHER	14. Maiden Name	Helen Wylie
	15. Birthplace	S. C.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7. 48 (month) (day) (year)
(c) Cemetery or crematory Int Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Eugene O Wilson
(b) Address 1000 Burgettstown Ave Huntington Station, Md.

OCT 6 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 - 1948 at 11 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 1 - 1948 to 10 - 3 - 1948. and that I last saw him alive on 10 - 3 - 1948.

Immediate cause of death	Duration
Congenital Cardiac malformation	
Due to	
Due to	
Other Conditions ? left polycystic Kidney	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury
23. Signature John J Ryan
Address Johns Hopkins Hosp Date signed 10 - 5 - 48 (M) (D)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 189

667396

ES-123347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667396 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elmira Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years 89? | Months | Days | If less than one day hr min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name UNABLE TO OBTAIN ANY FURTHER
13. Birthplace INFORMATION.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS.
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof oct 7-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Edmondson Ave

19 (a) 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 (mo) 48 (yr) at 6:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-28 (mo) 48 to 10-1 (mo) 48 and that I last saw her alive on 10-1 (mo) 48

Immediate cause of death: Bronchopneumonia, terminal — Duration: 3 days.

Due to

Due to

Other Conditions Generalized arteriosclerosis — 10 yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia; arteriosclerosis

PHYSICIAN: Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-2-48

VS 150

G67397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G67397

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road Entering Zuno
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Barnes Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores McLean

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1938

8. AGE: Years 10 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Sylvester Wilson
13. Birthplace Unknown

MOTHER
14. Maiden Name Eula McLean
15 Birthplace Unknown

16 (a) Informant Mother, Eula McLean
(b) Address 1418 Barnes St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Ave

19 (a) 10-9-48 (Date received by registrar) (b) Huntington Public Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/ 1948, at 12:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/ 1948, to 10/4/ 1948, and that I last saw her alive on 10/3/ 1948.

Immediate cause of death Tuberculous meningitis — Duration 9½ mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard M. Lobey M. D.

Address Sydenham Hospital Date signed 10/4/48

V S 150

Copy at age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667398 Registered No. 108

LCH 123322

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 dys.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1117 E. Lexington Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME: Ben Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Ben Handy

13. Birthplace Maryland

MOTHER — 14. Maiden Name Annie ?

15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. County, Md.

18 (a) Funeral director Joseph D. Koch, Jr.

(b) Address 1304 N. Central Ave

19 (a) (b)

(Date received by registrar) Registrar

OCT 8 1948 Huntington Williams, M.D.

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 2:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/27/48 to 10/2 to 48, and that I last saw him alive on 10/2/48

Immediate cause of death Lobar Pneumonia, right and uremia — Duration 1wk.

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease — 2 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia, toxic nephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Stutzman M. D.

Address Balto. City Hosp. Date signed 10-4-48

X

667399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

667399 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Elmtree Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FELICIA OLESCUK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-28-6133

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Boleslaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1891

8. AGE: Years: 57 | Months: 7 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Litvia
(Town, county, and state)

10. Usual Occupation: Charwoman

11. Industry or business: B lto. Trust Bldg.

FATHER
12. Name: Maarbett Wallis
13. Birthplace: Litvia

MOTHER
14. Maiden Name:
15. Birthplace: Litvia

16 (a) Informant: Boleslaw Olescuk
(b) Address: 1522 Elmtree St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 9, 1948 (month) (day) (yr.)
(c) Cemetery or crematory: Holy Cross
Location: A.A. County

18 (a) Funeral director: Wm. S. Fialkowski
(b) Address: 2007 Eastern Ave.

19 (a) (b) Received by registrar Washington Nelligan, M.D.

VS 151

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: October 5 1948, at 11:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis
Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature: W. S. Fialkowski M.D.
Medical Examiner.

Date signed 10-6-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667400

Hal 5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667400
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Cove St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Hickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Herman

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 5-27-86

8. AGE: Years 62 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Monball
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 8 (day) 48 (year)
(c) Cemetery or crematory Crisfield
Location Crisfield Maryland

18 (a) Funeral director H. Harvy Bradshaw
(b) Address Crisfield, Maryland

19 OCT 6 - 1948 (Date rec'd by registrar) Burlington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1948, at 12:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 10-6 1948, and that I last saw her alive on 10-6 1948.

Immediate cause of death: Intestinal Obstruction — Duration

Due to Generalized concinomatosis

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/25/48

Major findings of operation: generalized carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Gearhart, M.D.
Address John Hopkins Hospital Date signed 10/6/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G67401 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 211 Pearl St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto City

(c) City or town Balto City (If outside city or town limits, write RURAL and give town)

(d) Street No. 211 Pearl St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Rev Joshua Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mamie Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER

12. Name Joshua Williams

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah ?

15. Birthplace Maryland

16 (a) Informant Mamie Williams

(b) Address 211 Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna ave

19 (a) (Date received by registrar) Huntington Williams M.D.

(b) Registrar

10-6-48

Form VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1948, at 10:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1948 to 10/5 1948.

and that I last saw him alive on 10/4 1948.

Immediate cause of death Lobar Pneumonia — Duration 10 days

Due to

Due to

Other Conditions Arteriosclerosis

Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm Carman M.D.

Address 213 Cornyn St Date signed 10/6/48

G67402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G67402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Wheeling
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOGE GEORGE - GEORGE T. HOGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Rauschenberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1884

8. AGE: Years 64 | Months 7 | Days 15 | If less than one day 14 hr. min.

9. Birthplace Wheeling W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William V. Hoge
13. Birthplace W. Va.

MOTHER
14. Maiden Name Virginia Hylund
15. Birthplace W. Va.

16 (a) Informant Mr. George T. Hoge Jr.
(b) Address Wheeling, W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)

(c) Cemetery or crematory
Location Wheeling W. Va.

18 (a) Funeral director Wm. J. Tuchner & Sons
(b) Address 1st & Chapline Ave Wheeling W. Va.

19 (a) Date 10-6-48 (b) Registrar Huntington W. Va.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948 at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1948, to 10-5 1948, and that I last saw him alive on 10-5 1948.

Immediate cause of death	Pulmonary embolism post operative	
Due to	Ca Thyroid Gland	
Due to	Ca of Urinary Bladder with Generalized Metastasis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation October 3 1948

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Bolleroze M. D.
Address Sinai Hospital Date signed 10/6/48

OCT 6

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67403

IS-122851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67403
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2553 Flora Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1857

8. AGE: Years	Months	Days	If less than one day
91	5	9	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hammond
13. Birthplace Md.

MOTHER
14. Maiden Name Annie?
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 10/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) OCT 6 - 1948 (b)
(Date rec'd by registrar) Registrar

Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4- 19 48, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10-48 to 10-4 19 48
and that I last saw him alive on 10-4- 19 48

Immediate cause of death Bronchial Pneumonia — Duration 7 days.

Due to

Due to

Other Conditions Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Arteriosclerotic gangrene foot L.

of autopsy: Evidence of pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman Cole, M.D.
M. D.

Address 714 Fairmount Ave Date signed 10-5-48

VS 150

667304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. (667304)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. GROSS, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1928

8. AGE: Years	Months	Days	If less than one day
20	-	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John W. Gross, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna James Gross
15. Birthplace Balto., Md.

16 (a) Informant Sophia Burley
(b) Address 222 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 7, 1948. (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 OCT 6 - 1948 (Date rec'd by registrar) Covington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948. at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of left chest and abdomen.
Atelectasis of left lung

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 10-2-48 at Approx. 11:30 P. M.
(b) Where did injury occur? Carrollton Avenue and Mulberry Street
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-4-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

G67405 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Asquith St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Asquith St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Coe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Jefferson Coe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 1, 1851

8. AGE: Years	Months	Days	If less than one day
97	1	3	hr. min.

9. Birthplace Accomac Co., Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Abraham Glenn.
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15 Birthplace Va.

16 (a) Informant A. M. E. Home.
(b) Address 112 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date 1948 (b) received by Registrar, Mar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948, to Oct 4 1948, and that I last saw h[illegible] alive on Oct 3 1948.

Immediate cause of death, Carcinoma - Rheumatism & Hypertension

Duration 5 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury
23. Signature W. Stewart M. D.
Address 632 W. Lexington Date signed Oct 5

VS 150

X

- correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67306 3698 — Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1197 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 None
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1197 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No Yes or No)
If yes, name country

3 (a) FULL NAME Priscella Thompson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C.	married

6 (b) Name of husband or wife Henry Thompson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	3	hr. min.

9. Birthplace Dudley, N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Cox
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah
15 Birthplace N.C.

16 (a) Informant Irma Scott.
(b) Address 1197 N. Fulton Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof October 6, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Goldsboro, N.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) 1948 (b) (Date rec'd by registrar) Registrar

Burial to Goldsboro, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4- 1948 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1948 to 10-4- 1948.
and that I last saw her alive on 10-3- 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 6 days

Due to

Due to

Other Conditions: Hypertension and arteriosclerosis — Duration: unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Saunders M D
Address 029 N. Stricker Date signed 10-4-48

VS 150

Certify age is especially important. Physicians: please write the causes of death clearly and legibly.

G67307 48-21454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1581

G67307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Eagle st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gary Howard Rozzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1940

8. AGE: Years	Months	Days	If less than one day hr.	min.
1 day		1		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Rozzell
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Jessie Rogers
15. Birthplace Baltimore, Md.

16 (a) Informant Jessie Rozzell
(b) Address 1832 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 6, 1940 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1940 (Date) (b) Huntington Williams (by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1940, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Duration

Immediate cause of death Respiratory failure

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. J. Cooper M. D.

Address 2 S 9 h. Carey St Date signed 10-5-40

667408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-7

Registered No. 667408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(g) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA M. WARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1879

8. AGE: Years 68 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home

FATHER
12. Name Machael Schultz
13. Birthplace Poland

MOTHER
14. Maiden Name Dora (Unknown)
15. Birthplace Poland

16 (a) Informant Thomas Ward
(b) Address 2333 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 6800 Eastern Avenue

18 (a) Funeral director LILLY & ZEILER, INC.
(b) Address 403 S. Wolfe St. Balto. 31.

19 (a) (b) (Date received by registrar)

OCT 6 - 1948

VS 1st

Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, 10:10A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelosi M.D.
Medical Examiner.
Date signed 10-5-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC-4B-18865
667409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154 Registered No. 667409

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and name town)
(d) Street No. 821 Chuna Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Infant Baby Boy Spence
3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 30 48

8. AGE: Years	Months	Days	If less than one day
	1	335	Hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerome H Spence
13. Birthplace Balto Md

MOTHER
14. Maiden Name Grace A Young
15. Birthplace Howard County

16 (a) Informant Jerome H Spence
(b) Address 821 Union St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemt
Location A A Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 16 W Montgomery St

19 (a) (Date received by registrar) Thurlington Williams Registrar

OCT 6 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1948, at 6 04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948 to 10-4 1948, and that I last saw him alive on 10-4 1948.

Immediate cause of death Respiratory failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J J Hreden Jr M.D.
Address Univ. Hosp Date signed 10-4-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G67410
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution:
Sydenham Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Bond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 12 - 33

8. AGE: Years	Months	Days	If less than one day
15	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER	12. Name Sam Eaton
	13. Birthplace Littleton, N.C.
MOTHER	14. Maiden Name Nora Johnson
	15. Birthplace Littleton, N.C.

16 (a) Informant mother
(b) Address 1127 Bond St

17 (a) Removal (b) Date thereof 10/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N.C.

18 (a) Funeral director Mrs. Ross & Ellwood Dy
(b) Address 1129 N. Carlton St

OCT 6 1948
(Date rec'd by registrar) (b) Registrar

Turlington Williamsburg

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 5 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 28 1948, to 10 5 1948, and that I last saw him alive on 10 4 1948.

Immediate cause of death	Duration
Neo Carcinoma	
Due to	
Due to	
Other Conditions Nausea & Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Carter M. D.
Address Sydenham Hosp Date signed 10 5 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

Correct Name
Benjamin Franklin Harrell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Balto~~ Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Regester Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME B. Frank Harrell Benjamin Franklin Harrell

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Elizabeth M. Harrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1881

8. AGE: Years 66 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace: Cherry Lake Florida
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Marcus I. Harrell
13. Birthplace: Florida

MOTHER
14. Maiden Name: Missouri Coffee
15. Birthplace: Cherry Lake, Florida

16 (a) Informant: Mrs. Charles R. Mueller
(b) Address: 614 Kingston Rd. Balto. 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Balto. Co. Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves. Balto. 17.

19 10/6/48 (Date entered by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1948 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Neff M.D.
Medical Examiner.
Date signed Oct 4, 1948

VS 191

6741 2 St - 48 - 1325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 652112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor + Dukeland
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Hommel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Marrow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years | Months | Days | If less than one day hr. 38 min.

9. Birthplace West Balto General Hosp
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Marrow
13. Birthplace Italy

MOTHER 14. Maiden Name Esther Farchione
15. Birthplace Milwaukee Wisc

16 (a) Informant Mrs Esther Marrow
(b) Address 452 Hommel St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 30 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 6 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11/48 19 . at 11 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/ 1948 to 9/11/ 1948.
and that I last saw h[illegible] alive on 9/11 1948.

Immediate cause of death Intra-cranial Hemorrhage, massive atelectasis, bilateral

Duration: 1 day 1 day

Due to causes unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Intracranial Hemorrhage + atelectasis,

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P A Young M.D.
Address West Balto Gen. Hosp Date signed 9/24

VS 150

Type or write with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667413

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto. city
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Chas St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country. Canada

3 (a) FULL NAME Leroy King

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years: 60 | Months: | Days: | If less than one day: ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Painter

11 Industry or business .....

FATHER
12. Name John King
13. Birthplace Md.

MOTHER
14. Maiden Name .....
15 Birthplace .....

16 (a) Informant Wm Huber
(b) Address Wheeling W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6th 1948 (month) (day) (year)

(c) Cemetery or crematory
Location Wheeling W. Va.

18 (a) Funeral director Leo G. Cook
(b) Address 201-13 N. Patterson Park Ave

19 (a) 10/5/48 (Date rec'd by local registrar) (b) Washington Millinery, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1948, at 6 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 10-1 1948 and that I last saw him alive on 10-1 1948

Immediate cause of death Coronary occlusion — Duration .....

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Brian O'Connell, Jr. M.D.
Address Mercy Hosp Date signed 10-2-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 C

Registered No. G67414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 St. Paul Street
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County *******
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 St. Paul St. (If rural give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country *********

3 (a) FULL NAME Lucetta Moore Scopinich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife A. Antonio Scopinich
6 (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1852

8. AGE: Years	Months	Days	If less than one day
95	11	1	** hr. ** min.

9. Birthplace Bermuda
(Town, county, and state)
10. Usual Occupation None
11. Industry or business *******

FATHER
12. Name Isaac Peck Cooper
13. Birthplace Bermuda

MOTHER
14. Maiden Name Elizabeth Jane Kempold
15. Birthplace Bermuda

16 (a) Informant Antonio James Scopinich
(b) Address 3947 Cloverhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Ko. W. Mears and Son
(b) Address 800 N. Calvert Street

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 5 1948.
and that I last saw her alive on Oct 5 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 Mo.
Due to Stroke	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Clarence [illegible] M.D.
Address 2806 Woodbourne Date signed 10/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hayne's & Lakeland Aves.
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Berwick ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Zeller

3 (b) If veteran, name war ****

3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Joseph Zeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 1, 1884

8. AGE: Years	Months	Days	If less than one day
64	1	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Schmeda
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gottschalk
15. Birthplace Baltimore, Maryland

16 (a) Informant Lolores Zeller
(b) Address 2912 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director K. W. Meary & Son
(b) Address 805 N. Calvert Street

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1948 to Oct 5 1948 and that I last saw h[illegible] alive on Oct 5 1948.

Immediate cause of death	Duration
Cardiorespiratory arrest	
Due to Arteriosclerotic Cardiovascular Disease	10 yrs.
Due to	
Other Conditions Coronary Artery Disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Lewis Silverstein M. D.
Address West Balto Gen Hosp Date signed 10/6/48

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 667416

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3707 Beehler Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ida Hassid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Lata Julius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1901

8. AGE: Years	Months	Days	If less than one day
47	5	24	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation —

11. Industry or business Housewife

FATHER
12. Name David Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Chickoff
15. Birthplace Russia

16 (a) Informant Mrs. Goldie Wolf
(b) Address 3707 Beehler Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 7 48 (month) (day) (year)
(c) Cemetery or crematory Chevra Kadisha Corp.
Location Rosedale, Hamilton Avenue

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 124-26 W. North Avenue

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Philadelphia

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 9:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945, to Oct 6, 1948. and that I last saw her alive on Oct. 6 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Renal Debility	
Due to Carcinomatosis (Ovarian origin?)	
Other Conditions Pyelitis & Intestinal Obstruction	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D.
Address University Hosp Date signed 10-7-48

VS 150

667417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 667417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale Home Belvidere ave
(d) Length of stay in hospital or inst. (yrs., mos.) or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Park Heights ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Sandler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Lata Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Morris Sandler
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Meyer Sandler
(b) Address 2815 Violet ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Blvd
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Philadelphia Pa (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6th 1948 at 9.54 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1948, to October 6 1948, and that I last saw h[illegible] alive on October 6 1948.

	Duration
Immediate cause of death: Cerebral thrombosis	
Due to: Cerebral arteriosclerosis	
Due to:	
Other Conditions: Status post left side hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Levindale Home Date signed 10/6/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution:
Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 W. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LUCY HINES

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/5/1883

8. AGE: Years 65 | Months 5 | Days 29 | If less than one y: hr. min.

9. Birthplace Stoney Creek, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alonzo Freeman
13. Birthplace Va

MOTHER
14. Maiden Name Lucy J. Freeman
15. Birthplace Petersburg, Va.

16 (a) Informant Bessie Brown(D)
(b) Address 1533 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrellton Ave

19 (a) OCT 7 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/48 19 , at 10:00 A

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Oct 4 1948, and that I last saw him alive on Oct 2 1948.

Immediate cause of death: Myocardial Infarction — Duration: unknown

Due to (b) Arteriosclerosis — Duration: unknown

Due to (c)

Other Conditions

(Include) regnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen Coleman
Address 4611 Edmondson Date signed 10/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 667419 Registered No. 556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gatow & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Dorsey Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Zuck

3 (b) If veteran, name war

3 (c) Social Security Account No. ----

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thelma D Zuck

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Sept. 22, 1888

8. AGE: Years: 60 | Months: 0 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Mt. Clare Balto. Ohio RR

FATHER
12. Name: John A. Zuck
13. Birthplace: Pittsburgh, Pa.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Walter Zuck
(b) Address: Dorsey, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Dorsey Md.

18 (a) Funeral director Wm Pitt Donaldson
(b) Address Laurel Maryland

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28/ 1948 to 10/5 1948. and that I last saw him alive on 10/5/ 1948.

	Duration
Immediate cause of death CARDIO-RESPIRATORY FAILURE	
Due to TERMINAL UREMIA	
Due to MULTIPLE MYELOMA	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/14/48 Endo Urol
Major findings of operation: ENDOTHELIOMA MYELOMA OF BONE -
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or Homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Shaw M. D.
Address St. Agnes Hosp. Date signed 10/6/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. 667420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EUGENIA WHITNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1910

8. AGE: Years 38 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Brunswick, Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eugene Wilson
13. Birthplace Americus, Georgia

MOTHER
14. Maiden Name Mamie L. Hall
15. Birthplace Americus, Georgia

16 (a) Informant Holland Funeral Home
(b) Address 1631 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at 8:10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Royer M.D. Medical Examiner.
Date signed 10-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

667421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

667421 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rosa Louise Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Warren H. Andrews
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept. 14, 1881

8. AGE: Years	Months	Days	If less than one day
67		21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph A. Albrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Hess
15. Birthplace Germany

16 (a) Informant Miss Lillie E. Albrecht
(b) Address 1710 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director Albert L. Kelly Jr.
(b) Address 1606 N. Chester Street

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Matthews, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 3, 1948, to October 5, 1948, and that I last saw her alive on October 5, 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Lobar pneumonia	
Due to	
Other Conditions Cerebro-vascular Accident (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Bilateral pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hospital Date signed 10-5-48

X

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46F

Registered No. G67122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH BERNINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Andrew Berninger
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) May 10, 1870

8. AGE: Years	Months	Days	If less than one day
78	4	24	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hollar
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant: Andrew Berninger
(b) Address 3908 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetary
Location

18 (a) Funeral director E. Sanders & Sons
(b) Address N. Ave. & Broadway

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar Naturaux

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 10:15 M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of gall-bladder with metastases to liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/5/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 674423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 674423

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Duskin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Frank Duskin
(b) Address 1814 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory
Location Nethow Herring Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 2460 Eutaw Place

19 OCT 7 1948 (Date rec'd by Registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-48 19 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 48 to Oct 7 19 48. and that I last saw h / alive on Oct 6 19 48

Immediate cause of death: Coronary Thrombosis — Duration 3 Weeks

Due to: Arteriosclerosis

Due to:

Other Conditions: Diabetes Mellitus — 10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature 501 Smith.

Address 1223 E. North Date signed 10/7/48

VS 150

940

1674 24 H2H-2

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 1674 24

CERTIFICATE OF DEATH

1 STE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ontario (b) County
(c) City or town Toronto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Avenne Road. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Canada

3 (a) FULL NAME Patrick Hugh Love.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-21-48

8. AGE: Years	Months	Days	If less than one day
	2	7	hr. min

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Denis Love ?
13. Birthplace

MOTHER
14. Maiden Name Doris ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hart-Sinai

18 (a) Funeral director
(b) Address

19 OCT 7 - 1948 (Date rec'd by Registrar) (b) Huntington Md. (City or town) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 10-6 1948 and that I last saw him alive on 10-6 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cardiac Decompensation	
Due to Congenital Heart Lesion	
Other Conditions Congestion of Viscera	

(Include pregnancy within 3 months of death)

Date of operation Oct 5, 1948

Major findings of operation: Congestion of Viscera

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D A Cooley (Attending physician) Johns Hopkins Hospital Oct 6 '48 (Date signed)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital, Institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1947 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Sue Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife William F. Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1902

8. AGE: Years	Months	Days	If less than one day
46	5	1	hr. min.

9. Birthplace Toronto, Canada
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Annie Wamsley
15. Birthplace England

16 (a) Informant William F. Ward
(b) Address 2800 Clearview Ave

17 (a) Burial (b) Date thereof 10/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave

18 (a) Funeral director Howard H. Bligh Jr.
(b) Address 6009 Dalford Road

OCT 7 - 1948
(Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1948 to Oct. 5, 1948.
and that I last saw her alive on Oct. 5, 1948.

Immediate cause of death	Duration
massive gastro-intestinal hemorrhage	
Due to Penetrating gastric ulcer.	
Due to	
Other Conditions Central nervous system syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gastro-intestinal hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm. H. Rodgers M.D.
Address St. Joseph's Hospital Date signed 10-5-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67426

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Randall Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nelson Lee Tinsley

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lavina F. Tinsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1885

8. AGE: Years 62 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Wagonsman

11. Industry or business State of Maryland

FATHER
12. Name Frank Tinsley
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Fennick
15. Birthplace Maryland

16 (a) Informant Mrs. Lavina F. Tinsley
(b) Address 2 Randall Ave. Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-1948 (month, day, year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 7 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Adrian G. Spurrier M.D. Medical Examiner
Date signed Oct 5th 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

Order 6
667427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

667427
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Zaniewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-08

8. AGE: Years	Months	Days	If less than one day
40	2	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

PATHER
12. Name Stanislaw Zaniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Sophie Kasmaczewska
15. Birthplace Poland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/48 (month), (day), (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1938 Eastern Ave

19 (a) OCT 7 1948 Registrar Baltimore Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948, to 10-5 1948, and that I last saw him alive on 10-5 1948.

Immediate cause of death Spontaneous tension pneumothorax - right side. | Duration 4d.

Due to Pulmonary tuberculosis - active

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature [illegible] Jackson MD
Address [illegible] Date signed 10/5/48

VS 150

67428 48-2925

BALTIMORE CITY HEALTH DEPARTMENT ✓ 67428 Registered No.

CERTIFICATE OF DEATH 15E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: Mercy Hospital, Balto. Md
(d) Length of stay in hospital or inst. (~~yrs. mos. or~~ days) 8
(e) Length of stay in Baltimore (~~yrs. mos. or~~ days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Fleet St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward ~~Galcyn~~ Galczynski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 29, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	8	— hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER 12. Name Charles Galczynski

13. Birthplace New Jersey

MOTHER 14. Maiden Name Stephanie Malanowski

15. Birthplace

16 (a) Informant Charles Galczynski

(b) Address 1918 Fleet St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 8/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ozarowski

(b) Address 1930 Eastern Ave

19 OCT 7 1948 Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 6 1948. and that I last saw h~~im~~ alive on Oct 6 1948

Immediate cause of death

Cardiac Failure

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature A. M. Bacon Jr. M. D.

Address Mercy Hospital Date signed 10-6-48

VS 150

G67429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-2a

G67429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Guilford Ave
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Tregor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Nora A. Tregor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17th 1883

8. AGE: Years	Months	Days	If less than one day
64	11	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Marcus Tregor
13. Birthplace Germany

MOTHER
14. Maiden Name Rosalie (Markuson)
15. Birthplace Germany

16 (a) Informant Mrs. Nora A. Tregor
(b) Address 3129 Guilford Ave

17 (a) Cremation (~~Burial~~, cremation, ~~or removal~~) (b) Date thereof 10/8/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1948, at 2.30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5-1948. to 10-6-1948 and that I last saw him alive on 10-6-1948.

Immediate cause of death	Duration
Cerebral Hemorrhage Rt.	12 hrs.
Due to Hemiplegia	
Due to Arteriosclerosis	12 hrs
Lt. Hemiplegia	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Nathan Hillel M. D.
Address Calvert & 30th St. Date signed 10-7-48

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667430

55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Kerens (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Columbus Kerens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Grace Kerens
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1-27-90

8. AGE: Years 58 | Months 8 | Days 11 10 | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Columbus Kerens
13. Birthplace W. Va.

MOTHER
14. Maiden Name Jennie Carr
15 Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Elkins (b) Date thereof 10 7 48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Elkins
Location Elkins W Va

18 (a) Funeral director Pullman & Kee
(b) Address 1219 Druid Pk

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) [illegible] Baltimore, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 4 1948, to 10 - 6 1948, and that I last saw him alive on 10 - 6 1948.

Immediate cause of death: Myocardial Infarction, Massive — Duration: 6 hours
Due to Coronary Thrombosis — 6 hours
Due to
Other Conditions Mixed Tumor of Parotid Gland (Include pregnancy within 3 months of death)
Date of operation 10/5/48
Major findings of operation: Mixed Tumor of Parotid Gland
of autopsy: Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Alan Gibbs
Address Johns Hopkins Hospital Date signed 10/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Mayfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Mayfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna K. Richter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Standard Oil Co.

FATHER
12. Name John Schmidt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary M. Winteroth
15. Birthplace Tenn.

16 (a) Informant Anna K. Schmidt
(b) Address 3409 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) OCT 7 1948 (Date received by registrar) Interment for Williams Undertaking Co. Bal. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 48 at Sick M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 19 41 to Oct 4 19 48, and that I last saw him alive on Oct 4 19 48

Immediate cause of death: Coronary Thrombosis — Duration 4 years ?
Due to Cardio Vascular Typhus
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S. Bayley M.D.
Date signed 10/7/48 M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st Street
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 yr. 1 mo. 11
(e) Length of stay in Baltimore (yrs., mos., or days): as "d"

2. USUAL RESIDENCE OF DECEASED:
(a) State: Miss (b) County:
(c) City or town: Pheba
(If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: LEE, ROBERT FRANKLIN

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	s

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 19, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	14	hr. min.

9. Birthplace: Pheba, Miss (Town, county, and state)
10. Usual Occupation: painter
11. Industry or business: -

FATHER
12. Name: George Franklin Lee
13. Birthplace: Pheba, Miss

MOTHER
14. Maiden Name: Ella Shooteman
15. Birthplace: Miss

16 (a) Informant: Records
(b) Address: U S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct-7-48 (month) (day) (year)
(c) Cemetery or crematory: St Peters
Location: Lyman Ave

18 (a) Funeral director: Ray B Woodrow Inc
(b) Address: 402 E. 25th St

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, Mgr. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3, 1948, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1947 to Oct. 3, 1948 and that I last saw h im alive on Oct. 3, 1948

	Duration
Immediate cause of death: 1-Carcinoma of penis, post-operative state, with metastases to regional	
Due to: and periaortic nodes	2 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson M. D.
Address: Clinical Director Date signed 10-4-48

To 67433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 26383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4425 Forrest View Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Forrest View Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Duczar or Ducar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Eva Duczar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1 1871

8. AGE: Years	Months	Days	If less than one day
77	6	4	hr. min.

9. Birthplace Hungary (town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Duczar
13. Birthplace Hungary

MOTHER
14. Maiden Name unknown
15. Birthplace Hungary

16 (a) Informant Elisabeth Duczar
(b) Address 4425 Forrest View Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Road

18 (a) Funeral director Marie E. Fiskowski
(b) Address 1000 S. Kenwood Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948 at 11 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2. 1948 to Oct 5 1948. and that I last saw h alive on Oct 4 1948.

Immediate cause of death	Duration
Pulmonary failure	3 hrs.
Due to Ch. myocarditis	
Due to Sclerosis of Coronary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Standing M. D.
Address 350 S. Belnord Ave Date signed 10/7/48

VS 150

6674:34

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

6674:34 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Arlington Nursing Home
(b) Street address 3520 Hilton
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret P. Legg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Nicholas N. Legg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1863

8. AGE: Years	Months	Days	If less than one day
84	10	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Scanlon
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Eleanora A. Altwater
(b) Address 2752 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8th 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. & Mrs. John F. Seufert & Son
(b) Address 5316 Edmondson Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948 to Oct. 5, 1948. and that I last saw h alive on Sept. 29, 1948.

Immediate cause of death Myocardial Insufficiency — Duration 7

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy M. D.
Address 232 E Eastern Ave Date signed 10/5/48

VE 8

674335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30a

674335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N. Stricker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Stricker
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Norris

3 (b) If veteran, name war — W.W.I.

3 (c) Social Security Account No. 705-05-8172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Div.

6 (b) Name of husband or wife Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1890

8. AGE: Years	Months	Days	If less than one day
58	6	1	hr. min.

9. Birthplace Md Baltimore Cty.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Thos. P. Norris
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Ida Green
15. Birthplace Md

16 (a) Informant Wm Norris
(b) Address 900 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md.

18 (a) Funeral director Jos. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington for Phillips Mc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1947 to Oct 4 1948, and that I last saw him alive on Oct 4 1948.

Immediate cause of death Diabetes Mellitus
Had abscess formature of Scrotal Hydrocele 3 years ago.
Duration 3 years
Due to Progressive Uremia
Due to Convulsions Lasting 7 to 8 hours.
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Tongue M. D.
Address 926 N. Arlington Ave Date signed 10-6-48

VS 3

67436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67436

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2363 Denmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5303 Denmore ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/1893

8. AGE: Years 55 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden Name Josephine Duffin

MOTHER 15. Birthplace Md

16 (a) Informant Rev Richard Jackson

(b) Address 5303 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Publishing Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Oct. 1948, at 9:08 M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer M.D. Medical Examiner.

Date signed 6-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 23673137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town HALETHORPE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 OLD WASHINGTON BLVD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL HELWIG

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-7455

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARJORIE HELWIG
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr) 12-21-22

8. AGE: Years	Months	Days	If less than one day
25	9	16	15 hr. min.

9. Birthplace BALTIMORE COUNTY, MD. (Town, county, and state)
10. Usual Occupation MASON
11. Industry or business BUILDING

FATHER
12. Name HARRY HELWIG
13. Birthplace BALTO. COUNTY MD

MOTHER
14. Maiden Name CATHERINE LISNER
15. Birthplace BALTO. MD.

16 (a) Informant MARJORIE HELWIG
(b) Address 4115 OLD WASHINGTON BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory MEDOWRIDGE CEM.
Location WASHINGTON BLVD

18 (a) Funeral director Joseph T. Gontrum Jr.
(b) Address 1348 Shelphen Spring Rd.

19 OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Mills (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1948 at 4:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/26 1948 to 10/5 1948 and that I last saw him alive on 10/5 1948

Immediate cause of death Rheumatic Heart Disease - active — Duration

Due to

Due to

Other Conditions Cardiac Cirrhosis Uremia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Epstein M.D.
Address Sinai Hospital Date signed 10/5/48

VS 150

G67438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G67438
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital ~~or institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos. or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Gibbons Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mr. Oliver R. Nicklas

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 154-07-3926

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife. Irene Josephine Nicklas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 1, 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51	2	5		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation ~~None~~ Hotel Manager
11. Industry or business

FATHER
12. Name Andrew Nicklas
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Neva Rothert
15. Birthplace Baltimore Md.

16 (a) Informant: Irene Nicklas
(b) Address 3312 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Reistertown Road

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 South Wolfe St.

19 (a) OCT 1948 (Date rec'd by registrar) (b) Lexington / Pleasant Mill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1948 to Oct. 6, 1948 and that I last saw him alive on Oct. 6, 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Hypertensive-Cardio-Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two) (Place)
(e) Means of injury

23. Signature Frank W. Balogh, M. D.
Address St. Joseph's Hospital Signed 10-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

667439 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Boarman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS MARIE LONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced -----

6 (b) Name of husband or wife ----

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1941

8. AGE: Years 7 | Months 0 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Nashville, Tenn (Town, county, and state)

10. Usual Occupation ---

11. Industry or business --

FATHER
12. Name James Edward Long
13. Birthplace Ashland City, Tenn.

MOTHER
14. Maiden Name Essie Dubree
15. Birthplace Tenn.

16 (a) Informant James E. Long
(b) Address 2901 Boarman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1948 (month)
(c) Cemetery or crematory Govans Presbyterian
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Amadost
(b) Address 3911 Liberty Heights

19 (a) Date received (Registrar) OCT 7 1948 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION P.

20. DATE OF DEATH October 6, 1948, at 6:12 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Crushed Chest

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributory ☐ cause of death, fill in the following:
(a) Date of injury 10-6-48 5:55 P. M.
(b) Where did injury occur? Reisterstown Road and Boarman Avenue
(c) Did injury occur at home, on farm, in industrial place, in public place? Public (Which?) No
(d) Means of injury Ped struck by auto.

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed 10-7-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166

667440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM (N. M. I.) JOHNSON

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1905

8. AGE: Years	Months	Days	If less than one day
42	9	11	hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace New Orleans

MOTHER
14. Maiden Name Unknown
15. Birthplace New Orleans

16 (a) Informant Octavia Davis
(b) Address 1623 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)

(c) Cemetery or crematory
Location Baltimore National Cem.

18 (a) Funeral director A. Halsteadt
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar OCT 7 - 1948) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 4.05p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Generalized Peritonitis

Due to Bullet wound of Abdomen

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at approx. 5.30 p. M.
(b) Where did injury occur? 1623 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury firearms

23. Signature Earl K. Bryan M.D. (Medical Examiner)
Date signed October 5, 1948

G67441

BC-48-20168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56E

G67441
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Stockton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher John Zaleski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 25, 1948

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Baltimore, Balt. Co., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Stephen Zaleski
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Sarah Lepton
15. Birthplace North Carolina

16 (a) Informant Stephen Zaleski
(b) Address 1128 Stockton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1948 to Oct. 6, 1948 and that I last saw him alive on Oct. 6, 1948.

Immediate cause of death	Duration
Intestinal Obstruction	4 days
Due to Post operative (for)	4 days
Due to Enterogenous cyst, cecum	11 days
Other Conditions Peritonitis generalized Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation Oct. 2, 1948
Major findings of operation: Enterogenous cyst, cecum.
of autopsy: Peritonitis, bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

Certify age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

967442 ✓ 967442

951 Reg. Dist. No.

1. PLACE OF DEATH:
County 5707 WINNER AVE.
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5707 WINNER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME BEATRICE Rose STEINACKER

3. (b) Social Security Number —

4. Sex: FEMALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: WIDOWED
(b) Name of husband or wife: Edgar W. Steinacker
6.(c) If alive, give age ..... years
Birth date of deceased (mo., day, yr.): 10 - 14 - 1887
7. AGE: Years 60 | Months 11 | Days 22 | If less than one day: ..... hrs. ..... min.
8. Birthplace: Baltimore - Md (Town, county, and state)
9. Usual occupation: House wife
10. Industry or business: At Home
11. Name: Robert I. Christie
12. Birthplace: Maryland
13. Maiden name: Hariette Mathias
14. Birthplace: Maryland
15. Informant: Edgar W. Steinacker - Son
16. Address: 5014 Frederick Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/48 (month) (day) (year)
18. Cemetery or crematory: London Park
19. Location: Baltimore Md.
20. Funeral director: H. B. Wiltbert & Son
21. Address: 1300 Eutaw Place
OCT 7 - 1948 (Date rec'd by registrar)
Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1948 at 12 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to October 5, 1948 and that I last saw h.. alive on October 2 1948

Immediate cause of death: Coronary Occlusion — DURATION: 45 min

Due to: Rheumatic Heart Disease — years (?)

Due to: —

Other conditions: Obesity

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:-
Accident, suicide, or homicide: Date of —
Where did injury occur? — (City or town) — (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Louis Adman M. D. or other
Address 1413 Reisterstown Rd Pikesville
Date signed Oct 5, 1948

667443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 667443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Fait Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Fait Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Maryanna Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1866

8. AGE: Years	Months	Days	If less than one day
82	-	7	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Graff
13. Birthplace Germany

MOTHER
14. Maiden Name Unterkofler
15. Birthplace

16 (a) Informant Tekla Laniewski
(b) Address 2515 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cemetery
Location Dundalk Ave

18 (a) Funeral director John F. Duda
(b) Address 2829 Hudson St

19 OCT 7 1948 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Oct 5 1948, and that I last saw h[illegible] alive on Oct 4 1948.

Immediate cause of death	Duration
Arteriosclerosis	2 yrs.
Chronic nephritis. Uremia	2 wks.
Due to [illegible]	
Due to Senile debility	1 mo.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. A. Lopez M. D.
Address 432 S. Patterson Park Ave Date signed 10/7/48

VS 3

G67441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G67334

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Oakhill ave. (If rural give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma I Smith (VOLLMAN)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife: Charles Justus Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1874

8. AGE: Years 73 | Months 9 | Days 20 | If less than one day: hr. min.

9. Birthplace Md (Balto.) (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business

FATHER
12. Name John C. Vollman
13. Birthplace Germany

MOTHER
14. Maiden Name not known Rodeman
15. Birthplace Germany

16 (a) Informant Mr. Charles J. Smith
(b) Address 4011 Deepwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1948 at 10:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3 1948 to 10/6 1948, and that I last saw h[er] alive on 10/6 1948.

Immediate cause of death: Cardiac failure - Coronary Thrombosis - Duration

Due to arteriosclerotic Heart Disease

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D O Nuttle M.D.
Address Church Home Date signed 10/9/48

667445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

667445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Charles & 31st Street

(c) Hospital or institution: The Homewood Apts.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. Charles & 31st Sts.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Blanche Mills Besoré

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alpheus N. Besore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1875

8. AGE: Years 72 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER 12. Name: Ezekiel Mills, Jr.

13. Birthplace: Balto.

MOTHER 14. Maiden Name: Mary Virginia Porter

15. Birthplace: Balto.

16 (a) Informant: Mr. Charles Edwin Besore

(b) Address: 6417 Blenheim Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/46 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: W. J. TICKNER & SONS

(b) Address: Balto., Md.

(c) Date received by registrar 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1946, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 1946, and that I last saw her alive on Oct 6th 1946.

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William G. Stefpeck

Address 5006 Roland Ave. Balto 10 Date signed Oct 6 1946

VS 150

667446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

667346

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 E. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 E. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Hihn Thieme

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Charles H. Thieme
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 17, 1861

8. AGE: Years	Months	Days	If less than one day
87	6	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J. Bernard Hihn
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rauch
15. Birthplace Germany

16 (a) Informant Mrs. Norma T. Roberts
(b) Address 3822 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Fickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. 17, Md.

(a) OCT 7 - 1948 (Date received by registrar) (b) Livingston Phillipson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 6 1948 and that I last saw h[illegible] alive on Oct 6 1948

Immediate cause of death: Cardiac insufficiency — Duration: 2 days
Due to: General Arteriosclerosis — 5 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury WILBUR F. SHULMAN

23. Signature Hallen F. Phillipson M.D.
Address 6 E. Biddle St. Date signed 10/7/48

VS 150

667447 ✓ 667447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2832 Waterview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Waterview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Henry Sinclair

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Nioletta V. Sinclair
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 2, 1889

8. AGE: Years	Months	Days	If less than one day
59	8	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cloth Sponger
11. Industry or business

FATHER
12. Name John Sinclair
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ogle
15. Birthplace Md.

16 (a) Informant Mrs. Oliver Fisher
(b) Address 2832 Waterview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Ticknor & Sons, Inc.
(b) Address North & Pa. Aves. Balto. 17, Md

OCT 7 1948 (Date rec'd by registrar) (b) Burton Phillips MD

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to October 1948 and that I last saw him alive on October 2 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions Lymphogranuloma	

(Include pregnancy within 3 months of death)
Date of operation August 1948
Major findings of operation: Lymphogranuloma tumor of spleen
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris W. Steinberg M D
Address 410 N. Milton St Date signed Oct 7, 1948

VS 152

X

2 667448 667448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 S. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise A. Stout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles O. Stout
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1878

8. AGE: Years	Months	Days	If less than one day
70		17	hr. min.

9. Birthplace Hanover, Pa. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name William Dresher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Clouser
15. Birthplace Pa.

16 (a) Informant Charles O. Stout
(b) Address 36 S. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hanover, Pa.

18 (a) Funeral director Frederick J. Cole
(b) Address 2000 Linsbrad St

19 (a) OCT 7 1948 (b) Hanover Pennsylvania
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to 10/6 1948 and that I last saw her alive on 10/5 1948

Immediate cause of death: Coronary Thrombosis — Duration: 8 mos
Due to: & Cerebral
Due to:
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Cahn M.D.
Address 2145 W Balto St Date signed 10/7/48

3 667449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667449 Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSP
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County
(c) City or town BALTIMORE 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N WHEELER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MR. William CHARLES HAAS
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-01-4983

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
MALE	WHITE	Married

6 (b) Name of husband or wife MRS. ELVA HAAS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 23, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	12	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CHECKER
11. Industry or business A.P. WAREHOUSE

FATHER
12. Name HENRY HAAS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name LAURA V. LYONS
15. Birthplace BALTIMORE, MD.

16 (a) Informant Mrs. Elva F. Haas
(b) Address 114 N. Wheeler ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory New National
Location Baltimore

18 (a) Funeral director Frederick H. Cole
(b) Address 1210 W. Lombard St. (Funeral home) Baltimore, Md.

19 (a) OCT 7 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5, 1948 1948. at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1948. to 10/5 1948. and that I last saw him alive on 10/4 1948.

Immediate cause of death Heart Failure

Due to Portal Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp Date signed 10/5/48

correct age is especially important. Physicians: please write the causes of death clearly and le

VS 150

G67450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67450 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Mobile (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Conception St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WOODROW WILSON VAUGHAN

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 247-16-3630

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	w	s

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10, 1913

8. AGE: Years	Months	Days	If less than one day
35	5	6	hr. min.

9. Birthplace Westville, Fla. (Town, county, and state)
10. Usual Occupation seaman
11. Industry or business seafarer

FATHER
12. Name Henry I Vaughan,
13. Birthplace Westville, Fla

MOTHER
14. Maiden Name Lillie Belle Pittman
15. Birthplace Baymonte, Fla

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 10 48 (month) (day) (year)
(c) Cemetery or crematory DOTHAN
Location DOTHAN, ALABAMA.

18 (a) Funeral director JAMES F. DENNING INC.
(b) Address 715 LIGHT ST -30

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 7 - 1948

Washington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 3:15PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 9, 1948 to Oct 6, 1948, and that I last saw him alive on Oct. 6, 1948.

Immediate cause of death	Duration
1-Malignant melanoma with widespread metastases	15 mo.
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: not done	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson M. D.
Address Clinical Director Date signed 10-7-48

67451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

67451
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a. 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Frederick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA A. REINACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
White	Female	Widowed

6 (b) Name of husband or wife Sydney Reinach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1889

8. AGE: Years	Months	Days	If less than one day
59	6	19	hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation Restauranteur
11. Industry or business

FATHER
12. Name Louis Ruppersberger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Zuang
15. Birthplace Baltimore, Maryland

16 (a) Informant Walter T. Voigt
(b) Address 1600 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Road, Balto., Md.

18 (a) Funeral director Easton's Home
(b) Address 608 Fresh Air, Catonsville
Transferred to Williamsport, Md.

19 (a) Date received OCT 7 1948 (Registrar)
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at 6:10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
(a) Laceration of brain
Due to Intracranial hemorrhage
Fracture of neck
Other Conditions Fracture of ribs
Fracture of nose
(Include pregnancy within 3 months of death)

22. If an external cause was accident X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-5-48 at Approx. 6 p. M. 19/4
(b) Where did injury occur? 600 blk Frederick Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work?) no
(d) Means of injury Ped. struck by auto.

23. Signature George E. Warner M.D.
Medical Examiner.
Date signed 10-6-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully checked.

74152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 66745?

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Valley & Eager St.
(c) Hospital or institution:
Little Sisters of Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of Poor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Krach

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: August

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1871

8. AGE: Years: 77 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs Norman F. Smith
(b) Address: 2041 East 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 19 48, at 4:33 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48, to Oct 6 19 48 and that I last saw h alive on Oct 6 19 48.

Immediate cause of death: Edema Lung — Duration: 1 day

Due to: Hypertensive Cardio Vascular Disease — 3 yrs.

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature E Hartsdale M. D.
Address 1631 E North Ave Date signed 10/7/48

667453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 667453 Registered No. 93D

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1406 Filbert St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1406 Filbert St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William C. Pfarr

3 (b) If veteran, name war

3 (c) Social Security Account No. Lost

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Myrtle C Pfarr

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1900

8. AGE: Years 47 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER 12. Name Christian Pfarr

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace "

16 (a) Informant Mrs. M. Pfarr

(b) Address 1406 Filbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park,

Location Annapolis Md.

18 (a) Funeral director Chas. Hill

(b) Address 151 E. Fort

19 (a) OCT 8 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Oct 1948.

and that I last saw him alive on Oct 4 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to Hypertension cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Philip W. Kuster MD

Address 312 Palafox Date signed 10/6/48

Kuster

67454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 67454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital of Baltimore 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. CALA BLUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9[illegible]17

8. AGE: Years: 31 | Months | Days | If less than one day: hr. min.

9. Birthplace: Springfield Mass
(Town, county, and state)

10. Usual Occupation: Home wife

11. Industry or business

FATHER
12. Name: Israel Kuboritz
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sara
15. Birthplace: Russia

16 (a) Informant: Albert H. Blum
(b) Address: 2502 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory: Kesser Israel
Location: Springfield, Mass

18 (a) Funeral director: Jack Kewe Inc
(b) Address: 2160 Eutaw Place

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Huntington Millman (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Oct. 8 1948 and that I last saw h&r alive on Oct 8 1948.

Immediate cause of death	Duration
Acute myelogenous leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Aaron Sweed, M.D.
Address: Sinai Hospital Date signed 10/8/48

VS 150

67455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 167455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Fairview ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Latvia

MOTHER
14. Maiden Name Anda
15. Birthplace Latvia

16 (a) Informant Howard Berman
(b) Address 3510 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis, Inc
(b) Address 2120 Eutaw Place

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Registrar's Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1948, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/7 1948, and that I last saw her alive on 10/7 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Hypertensive Ht. Disease	
Left Ventricular failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard Oxenon, M.D. M. D.

Address Sinai Hosp. Baltimore Date signed 10/7/48

VS 150

X

G67456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. T correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument Street
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Morley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Guercio (Saverio Rosario Guercio)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-0157

4. Sex male | **5. Color or race** white | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Pasquale Guercio
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Tepentino
15. Birthplace Italy

16 (a) Informant Steve Guercio
(b) Address 27 N. Morley Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct. 9-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Joseph Sanace Inc.
(b) Address 2013 Greenmount Ave

19 OCT 8 - 1948 (Date rec'd by registrar) **(b)** Huntington Phillips, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1948 at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1948 to Oct 5 1948, and that I last saw h/m alive on Oct 5 1948.

Immediate cause of death Acute Pulmonary Edema

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Being done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Sinai Hosp Date signed 10/6/48

VS 150

Natural Causes X

667457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667457 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5906 Highgate Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5906 Highgate Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRVING BAER WEINBERG.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife DEANE Weinberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1899

8. AGE: Years	Months	Days	If less than one day
48	9	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mngr.
11. Industry or business

FATHER
12. Name Daniel Weinberg,
13. Birthplace Md.

MOTHER
14. Maiden Name Rena Baer,
15. Birthplace ?

16 (a) Informant Mrs. I. Weinberg
(b) Address 5906 Highgate Drive

17 (a) Cremation (b) Date thereof 10/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Burial Cremation
(b) Address 1812 Eutaw Place

19 (a) OCT 8 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Address 100 W. Monument St. Date signed Oct 7 48

Beny S. Adelsberg

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1948 to Oct 7 1948.
and that I last saw him alive on Oct 7 1948.

Immediate cause of death: Coronary Thrombosis — Duration 5 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

22. Signature Beny S. Adelsberg M.D.

67458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 E

Registered No. 67458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E. Wolfe St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E. Wolfe St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country U. S. A.

3 (a) FULL NAME Claude Adolphus Tulloch

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-05-4946

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Mary Tulloch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1901

8. AGE: Years 47 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace St. Louis Bay Jamaica (Town, city, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Doris Stewart (Dept. Friend)

(b) Address 1641 Midland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18. (a) Funeral director Robert F. Young

(b) Address 1216 W. Caroline St.

19 (a) OCT 8 - 1948 (Date rec'd by local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948 at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1948 to 10/7 1948 and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Myocarditis

Due to Lab-Hemolytic - Carcinoma Lymphoid — 6/17/48

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Allen L. Lynch M. D.

Address 5228 N. Bond St. Date signed 10/7/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

667459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Jarr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. J. W. Jarr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 28-1872

8. AGE: Years	Months	Days	If less than one day
75	10	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Louis Smith
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Norman Jarr
(b) Address 1425 N. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Co.
Location North Ave & Gay St

18 (a) Funeral director John A. Miller
(b) Address 233 E. Jefferson St.

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Huntington-Pittsburgh M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 19 48 at 9:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 19 48, to 10/6 19 48, and that I last saw h[illegible] alive on 10/5 19 48.

Immediate cause of death Coronary Thrombosis — Duration 1½ days
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 3400 E. Fort Ave. Date signed 10/7/48

3400 E. Fort Ave.

667460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667460

1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Newark, (If outside city or town limits, write RURAL and give town)
(d) Street No. 283 Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert DeMarco

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1917

8. AGE: Years 31 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Jockey
11. Industry or business

FATHER
12. Name Louis DeMarco
13. Birthplace Italy

MOTHER
14. Maiden Name Louise DiGianna
15. Birthplace Italy

16 (a) Informant Damiano Funeral Home
(b) Address Newark, N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-48
(c) Cemetery or crematory Holy Sepulcher Cemetery
Location Newark, N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 7:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion
Fatty degeneration of heart

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature Emil H. Beyer M.D.
Medical Examiner
Date signed 10-7-48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667461

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 215 Longwood Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 79

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 3

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 215 Longwood Road
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Clara Virginia Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) July 26/1865

8. AGE: Years	Months	Days	If less than one day
83	2	10	~ hr. ~ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Attilla Edward Stein M.D.

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Emerald Lawrence Stein

15. Birthplace Calvert Co.

16 (a) Informant William Henry Pilcher

(b) Address 215 Longwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location North & Greenmount Aves. Balto.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 5-05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from January 1943 to Oct 6 1948, and that I last saw her alive on Oct 6 1948

Immediate cause of death: Left Hemiplegia — Duration: 3 mos

Due to: arteriosclerosis

Due to:

Other Conditions: Terminal Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Vernon H. Norwood M. D.

Address 5101 Woodside Road Date signed 10-6-48

67462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87D

Registered No. 667462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution: Hillcrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Liberty Hts. Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No? If yes, name country

3 (a) FULL NAME Anna Louise Pracht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13/ 1883

8. AGE: Years	Months	Days	If less than one day
65	1	25	hr. 24 min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert C. Pracht
13. Birthplace Maryland Balto.

MOTHER
14. Maiden Name Emma Baetjer
15. Birthplace Balto. Md.

16 (a) Informant Helen Pracht
(b) Address 204 Cedar Croft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md. Balto. city

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Pl.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1941 to 10-6-1948, and that I last saw he alive on 10-5 1948.

Immediate cause of death	Duration
Multiple Cancer	7 yrs.
Due to	
Due to Myocardial failure	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Frank H. Garner M. D.
Address 2604 Garrison Blvd. Date signed

VS 150

IF NOT WRITING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G674663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G674663

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 N Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) all of life
(e) Length of stay in Baltimore (yrs., mos., or days) all of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N Luzerne Av (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Johanna Schoenhals

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Schoenhals

6 (c) If alive, give —

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1864

8. AGE: Years 84 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER / FATHER

12. Name Mr William Toepfer

13. Birthplace Germany

MOTHER

14. Maiden Name Miss Eleanor Scheffe

15. Birthplace Germany

16 (a) Informant Daughter

(b) Address 900 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Wilbur Funeral Home

(b) Address 800 E Lexington St

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 8:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 16 1947, to Oct 6 1948, and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death Myocardial Insufficiency — Duration

Due to Apoplexy —

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Monnington M.D.

Address 800 E North Ave Date signed 10/7/48

VS 2

Ex's. Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 667464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S. Bouldin (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Anna Lizzie Critzman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Wm T. Critzman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 3, 1874

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	7	4		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Greenwald
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Snyder
15. Birthplace Germany

16 (a) Informant Walter H. Critzman
b) Address 7009 Bartonia Ave

17 (a) Burial (Burial, cremation, or removal) b Date thereof Oct 11 (month) (day) (year)
(c) Cemetery or crematory St. Reformed Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948, at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 3, 1948 to October 7, 1948, and that I last saw her alive on October 7, 1948

Immediate cause of death	Duration
Coronary Occlusion	
Due to Hypertension C.V.D.	
Due to	
Other Conditions Fracture Hip Right.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/3/48 at 1:30 AM
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(e) Means of injury Fell down stairs

23. Signature John T. Ennis M.D.
Address St. Joseph's Date signed 10/7/48

CERTIFICATION APPROVED BY D. Earl Ross M.D.

VS 150

667465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

667465

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2501 E. Chase Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 2501 E. Chase Street
(If rural give location)

(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME MARY REBECCA SCHEPF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Howard Schepf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	17	hr. min.

9. Birthplace Quantico, Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business National Can Company

FATHER
12. Name Boatwright
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Howard Schepf - husband

(b) Address 2501 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or ~~Church~~ 1st United Evang. Luth.

Location

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 8 - 1948 (Date rec'd by Registrar) (b) Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-1948, at 12P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1948, to 10-6-1948, and that I last saw h.. alive on 10-6-1948.

Immediate cause of death Carcinoma - Ca of cervix with metastases — Duration 1 year

Due to

Due to

Other Conditions Nephrostomy — 7 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Yes or No)

(e) Means of injury

23. Signature Benj. B. Moore M. D.

Address 448 N. Luzerne Ave Date signed 10-6-48

VS 150

REMOVE WHITE COPY, WITH ENVELOPE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G87466

B-123450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-27

Registered No. G87466

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 E. Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schwarzkopf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of [redacted] or wife Catherine Krieger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1869

8. AGE: Years	Months	Days	If less than one day
79	3	18	hr. min.

9. Birthplace Md. Baltimore
(Town, county, and state)
10. Usual Occupation ? retired
11. Industry or business

FATHER
12. Name Henry Schwarzkopf
13. Birthplace ? Germany

MOTHER
14. Maiden Name Margaret
15. Birthplace ? Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [redacted]ry Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

19 (a) OCT 8 - 1948 (b) Huntington Williamsport Md.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948 at 10.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2- 1948, to 10-5- 1948, and that I last saw him alive on 10-5- 1948

Immediate cause of death	Duration
Cerebral Vascular Accident	5 days
Due to Hypertensive Cardio Vascular Disease	?
Due to	
Other Conditions arteriosclerosis gen. senes. (include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Krieger M.D.
Address Balto City Hosp Date signed 10-8-48

The information requested on this certificate is required by law (Section 4, Article 43, Annotated Code of Maryland, 1939 Edition, as amended). Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 White Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS ROOSEVELT BENDER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret Kendrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1901

8. AGE: Years	Months	Days	If less than one day
47	7	20	hr. min.

9. Birthplace Port Deposit, Md. (Town, county, and state)
10. Usual Occupation Landscaper
11. Industry or business

MOTHER / FATHER
12. Name Alfred Bender
13. Birthplace Philadelphia, Pa.
14. Maiden Name Mary Jane Long
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Margaret Kendrick Bender
(b) Address 2707 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 8 - 1948 (Date rec'd by Registrar) (b) Registrar Washington, Md.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 6 1948.
and that I last saw him alive on Oct. 6 1948.

Immediate cause of death Coronary occlusion — Duration
Due to Coronary Sclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Walter A Anderson M.D.
Address 3001 Sharon Drive Date signed 10/7/48

67468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 67468 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Berwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Berwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Miceli

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Augusta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 19-1877

8. AGE: Years	Months	Days	If less than one day
71	6	18	hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Miceli
13. Birthplace Italy

MOTHER
14. Maiden Name ✓
15. Birthplace Italy

16 (a) Informant Mrs. John Dockman
(b) Address 2714 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn N. Y.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948, to Oct 1948, and that I last saw h[illegible] alive on Oct 7 1948.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Old Myocardial Infarction	
Due to Coronary Thrombosis 1946	
Other Conditions Cirrhosis of liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in each case)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 10-8-48

95c

G67469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G67469 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4406 Rokeby Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr. Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Rokeby Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Caroline Lippert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Late Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	22	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm. Hoffman
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Gettier
15. Birthplace Md

16 (a) Informant Ruth Hardt
(b) Address 4406 Rokeby Rd.

17. Burial (b) Date thereof Oct. 11 | 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Henry H. Mitzel
(b) Address 401 Edmondson Ave

19 (a) Oct 8 - 1948 Huntington Pk
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 7 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Oct 8 1948.
and that I last saw her alive on Oct 7 1948.

Immediate cause of death	Duration
Carcinoma of Esophagus	?
Due to	
Due to	
Other Conditions Left Hemiplegia	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Cass, M.D.
Address 4001 Wilkens Ave Date signed 10-8-48

667470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 W. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 W. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Cuff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife Homer Cuff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years	Months	Days	If less than one day
66	8	8	hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elijah Holt
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Virgin Thomas
15. Birthplace Charles Co. Md.

16 (a) Informant Marie Cooper
(b) Address 2520 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 8 - 1948 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1947 to Oct 6 1948.
and that I last saw h alive on Oct 6 1948.

Immediate cause of death Cardiac Arrest — Duration

Due to Cerebral Thrombosis

Due to Senile Psychosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Yes or No)
(e) Means of injury

23. Signature Helen F. Cooper
Address 2015 Edmondson Ave Date signed 10/10/48

VS 150

G67471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G67471
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Woolford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1896.

8. AGE: Years	Months	Days	If less than one day
52	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Nathan Woolford.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sallie Woods.
15 Birthplace Baltimore Md.

16 (a) Informant Mrs. Sadie Bryan.
(b) Address 1439 Ward St.

17 (a) Is Burial (Burial, cremation, or removal) (b) Date thereof October 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 32 N. Schroeder St

19 (a) OCT 8 - 1948 (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947 to Oct 6 1948, and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death	Duration
Cerebral Thrombosis left	3 days
Due to Chronic Myocarditis & myocardial Degeneration	2 years
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr. M. D.
Address 122 N. Ward Blvd Date signed 10-7-48

VS 150

G67472 Bl 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G67472

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9

(d) Length of stay in hospital or inst. (yrs., mos., or days).

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2037 Harford Road (If rural give location)

(e) Citizen of foreign country? N (Yes or No)

If yes, name country

3 (a) FULL NAME William McKeldin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-1-83

8. AGE: Years 65 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name William McKeldin

13. Birthplace ?

MOTHER 14. Maiden Name Mary Scott

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48

(c) Cemetery or crematory Mt. Olivet Cem.

Location Frederick Rd.

18 (a) Funeral director Wm. H. Valentine

(b) Address 2326 Aiken St.

19 OCT 8 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1948, at 7:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1948 to 10-7 1948.

and that I last saw h alive on 10-7 1948.

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic cardiovascular disease

Due to Generalized arteriosclerosis

Other Conditions Emphysema-senile

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ASCVD E emphysema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature [illegible]

Address The Johns Hopkins Hosp. Date signed 10/7/48 M. D.

VS 150

674473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(31)

Registered No. 674473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Tracton St
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Tracton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie West Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife John Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	19	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mack West
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mildred Young
(b) Address 1412 Tracton St

17 (a) Burial (b) Date thereof 10/9
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 OCT 8 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1948 to Oct 6 1948 and that I last saw her alive on Oct 4 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	2 yr.
Due to Lymph angioma of both legs	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. William Frey M.D.
Address 1928 Penna Ave Date signed 10/8/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

To be Approved by Chief Medical Examiner

Medical Examiner's Case 67474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67474

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Yorkway
(If outside city, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

CERTIFICATION APPROVED BY

3 (a) FULL NAME FRANK W SRAVER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ETHEL T TURNER
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr SEPT. 29, 1891

8. AGE: Years 57 | Months 0 | Days 16 | If less than one day hr min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation R. R. CONDUCTOR RET.

11. Industry or business B & O. RAILROAD

FATHER
12. Name WM. SRAVER
13. Birthplace

MOTHER
14. Maiden Name KATHERINE
15. Birthplace

16 (a) Informant MRS. RUSSEL LANDON
(b) Address 2626 YORKWAY

17 (a) BURIED (Burial, cremation, or removal) (b) Date thereof OCT. 9 1948 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7225 EASTERN AVE.

18 (a) Funeral director Roland L Tisha
(b) Address 212 DUNDALK AVE

19 (a) OCT 8 1948 (Date received by Registrar) (b) Huntington Millspaugh (Registrar)

MEDICAL CERTIFICATION M. D.
CHIEF OR ASST. MEDICAL EXAMINER

20. DATE OF DEATH 10-6 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-28 1948, to 10-6 1948, and that I last saw him alive on 10-6 1948.

Immediate cause of death	Duration
Acute Pulmonary Edema & Pulmonary Emphysema	3 days
Due to Hypertensive Arteriosclerotic Cardiovascular Disease	10 years
Due to	years

Other Conditions Attempted Suicide June 1948 & Manic Depressive State
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema & Emphysema A530.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M. D. at M.
(c) Where did injury occur? (City or town) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

CERTIFICATION APPROVED BY
Medical Examiner, B.C.H.D.

CERTIFICATION BY PHYSICIAN
Edward A. Revell M. D.
Address 213 Light St. Date signed 10-6-48

VS 150

CHIEF OR ASST. MEDICAL EXAMINER

HLH Prem

GRANICKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667475

667475 BC-48-2130 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 14 S. Ann St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bubsy Bug Granicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
		1		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Theodore Granicki

13. Birthplace Balto Md

MOTHER — 14. Maiden Name Wanda Borys

15. Birthplace Balto Md

16 (a) Informant Theodore Granicki

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem Location German Hill road

18 (a) Funeral director Maria E. Fallon[illegible] (b) Address 1000 N. Kenwood Ave

19 (a) OCT 8 - 1948 (b) Huntington Md

(Date filed by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948. at 7.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1948. to 10-7 1948. and that I last saw him alive on October 7 1948.

Immediate cause of death Pneumothorax * Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Upami Upsons M. D.

Address JHH Date signed 10/8/48

VS 150

G67476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67476 ✓ 92

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Beltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. BOWEN, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie D. Bowen nee Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 14, 1860

8. AGE: Years	Months	Days	If less than one day
88	7	23	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Special Agent
11. Industry or business Timbrooks & Zimmerson

FATHER
12. Name George W. Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Malinda A. Nash
15. Birthplace Maryland

16 (a) Informant Mr. John W. Bowen, Jr., son
(b) Address 2420 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Pollaman, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1948 to 10/6 1948 and that I last saw h[illegible] alive on 10-6 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4hrs
Arterio Sclerosis	
Due to arterio sclerosis	4yrs
Due to	
Other Conditions Prostatitis - Operation (Include pregnancy within 3 months of death)	
Date of operation Oct 8, 1948	
Major findings of operation: Prostatic Hypertrophy	
of autopsy: Blood	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2040 N. Charles Date signed 10/8/48

VS 150

67477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 67477

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 E. 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. 27th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT B. COLBERT, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Harriett A. Colbert
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 7, 1890
8. AGE: Years: 58 | Months: 0 | Days: 9 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Supt.
11. Industry or business: J. F. . Dorman Co.

FATHER
12. Name: Robert B. Colbert
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Kate Callahan
15. Birthplace: Maryland

16 (a) Informant: Mrs. Harriett A. Colbert, Sr.
(b) Address: 335 E. 27th St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.
19 (a) OCT 8 1948 (Must be filed by registrar) (b) Huntington Phillips, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948, at 4:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8, 1947 to Oct. 6, 1948 and that I last saw him alive on Oct. 6, 1948

Immediate cause of death: Myocardial Failure — Duration: Immediate
Due to: Chronic Hypertension — Duration: 2 years.
Due to:
Other Conditions: Arteriosclerosis — Duration: 2 years.
(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation: none
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: none
(b) Date of occurrence: none at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none (Specify) While at work?
(e) Means of injury: none
23. Signature: Frank M. Ogden, M. D.
Address 2701 N. Calvert St. Date signed Oct. 7, 48.

VS 150

102

67478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 67478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 The Alameda
(c) Hospital or institution:

919

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEVERLY R. REID

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Spanish	no	male	white	widowed

6 (b) Name of husband or wife Grace L. Reid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1878

8. AGE: Years	Months	Days	If less than one day
70	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Robert M. Reid
13. Birthplace Scotland

MOTHER 14. Maiden Name Henrietta Burrough
15 Birthplace Virginia

16 (a) Informant Miss Marion Reid
(b) Address 2730 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Pittenger M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at noon M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Oct 7 1948.
and that I last saw h alive on Oct 6 1948

Immediate cause of death 1 Chronic Endocarditis — Duration 2 ?
Due to Failing Compensation 1 mo
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Pittenger M.D.
Address 9356 Maryland Ave Date signed Oct 8 48

VS 150

Hal-7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

Registered No. 667479

667479

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Metzger Way (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME David Shook

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-10-4948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Marjorie Shook
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr) 3-19-16

8. AGE: Years	Months	Days	If less than one day
32	6	18	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name William Shook
13. Birthplace W. Va.

MOTHER
14. Maiden Name Josephine Cockran
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Shinnston Masonic Cem.
Location Shinnston, W. Va.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Md. Plummer & Pittsburgh, Pa.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948 to 10-7 1948, and that I last saw him alive on 10-7 1948.

Immediate cause of death
Brain Tumor

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct 7, 48

Major findings of operation: Brain tumor rt temporal lobe

of autopsy: Brain Tumor Temporal lobe

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature George E. Culbreth M.D.
Address Johns Hopkins Hospital Date signed 10/8/48

VS 159

667480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 667480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5204 Tilbury Way

(c) Hospital or institution: at Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) ~~County~~ City of Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5204 Tilbury Way (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET PAINTER SHRYOCK

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Henry S. Shryock

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec-7-1885

8. AGE: Years	Months	Days	If less than one day
62	10	C	..... hr. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER

12. Name: Harold C. Painter

13. Birthplace: Owings Mills, Maryland

MOTHER

14. Maiden Name: Carrie Toole Hill

15. Birthplace: Louisburg, N. C.

16 (a) Informant: Mr. Henry S. Shryock, Jr. (son)

(b) Address: 3420 Fairhill Dr. Wash. D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-9-48 (month) (day) (year)

(c) Cemetery or crematory: St. Thomas Garrison Forest

Location: Owings Mills, Maryland

18 (a) Funeral director: Stewart & Mowen Company

(b) Address: 108 W. North Avenue, City #1.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948, to Oct 7 1948, and that I last saw her alive on Oct 6 1948.

	Duration
Immediate cause of death: Uremia	3 days
Due to Bastric carcinoma & metastases	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Stephen J Van Lill M. D.

Address 2743 St Paul St Date signed 10-8-48

VS 150

Medical Examiner's Case

G67481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G67481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Patterson Pk. Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Claire M. Ford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John T. Ford

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April 28, 1888

8. AGE: Years 60 | Months 5 | Days 12 | If less than one day — hr. — min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name James O. O'Neil
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Ruth
15. Birthplace Maryland

16 (a) Informant MRS Claire M. Ford.
(b) Address 1419 Pattersonan Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St.

OCT 8 - 1948 (Date rec'd by registrar) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~April 28~~ Oct. 6 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1948 to Oct 6 1948. and that I last saw her alive on Oct 6 1948.

	Duration
Immediate cause of death Infarction of Myocardium due to arterio-sclerotic coronary Thrombosis	9/29/48
Due to	
Due to Arteriosclerotic Heart Disease	10 years
Other Conditions Hypertensive Cardiovascular Disease 10 yrs. Fracture Left radius. 9/28/48	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: CERTIFICATION APPROVED BY

of autopsy: PHYSICIAN

The cause to which death should be charged statistically. M. D.

CHIEF OF BUR. MEDICAL EXAMINER.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 19, 1948 at — M
(c) Where did injury occur? 1419 N. Patterson Pk. Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Tripped over linoleum and fell to floor.

23. Signature L. M. Howard, M.D. M. D.
Address Church Home Hospital Date signed 10/6/48

CERTIFICATION APPROVED BY

M. E.

VS 150

667482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Galveston (If outside city or town limits, write RURAL and give town)
(d) Street No. Apt 107-A, Island City Homes (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WALTERS, HERBERT RODNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July [illegible], 1926

8. AGE: Years	Months	Days	If less than one day
22	2	26	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation seaman
11. Industry or business seafarer

FATHER
12. Name Rudolph Walters
13. Birthplace Texas

MOTHER
14. Maiden Name Clara Brundrett
15. Birthplace Texas

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct-8-48 (month) (day) (year)
(c) Cemetery or crematory Galveston
Location Texas

18 (a) Funeral director Ralph B. Wolverton Inc
(b) Address 423 E - 25th St.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Hilliard Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16, 1948 to Oct. 7, 1948, and that I last saw him alive on Oct. 7, 1948

Immediate cause of death	Duration
Acute Myeloid Leukemia	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. B. Monroe M. D.
Address USMH, Balto Date signed 10-7

BC-48-2160 2

667483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667483 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ells
(c) Hospital or institution: Rutland Ave Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Joseph ~~Bobby Boy~~ Brown Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1948

8. AGE: Years	Months	Days	If less than one day
		4 3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Walter J. Brown
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Angeline Constantino Guglielmo
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Walter J. Brown
(b) Address 824 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Samuel Israel Cemetery
Location Germantown Hill Road Baltimore Co

18 (a) Funeral director Edward W. Franklin
(b) Address 924 E. Eager St.

19 OCT 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Oct 8 1948, and that I last saw him alive on Oct 7 1948.

Immediate cause of death respiratory failure — Duration

Due to anoxia

Due to congenital heart disease, eg. atresia of pulmonary ring

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Seiphu M. D.
Address Sinai Hosp Date signed 10-8-48

VS 150

G67484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Rosewood Training School
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reginald Tyler

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Married

6 (b) Name of husband or wife Wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1887

8. AGE: Years	Months	Days	If less than one day
60	11	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Attendant
11. Industry or business (Rosewood Training Sch)

FATHER
12. Name Wallace Tyler
13. Birthplace Maryland

MOTHER
14. Maiden Name [redacted] Price
15. Birthplace Maryland

16 (a) Informant Wilhelmina Tyler
(b) Address 1711 N Bond St (Wife)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery, crematory Maryland Park
Location Baltimore Md

18 (a) Funeral director Wm Cook Inc
(b) Address 617 E Fayette St

19 (a) OCT 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1948, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 7 1948, and that I last saw h[e] alive on Oct 7 1948.

Immediate cause of death	Duration
Cardio-respiratory collapse	
Due to Cerebral Embolism	
Due to	
Other Conditions Fract-neck right femur	2½ mos.
Fract: supracondyles humerus right	

(Include pregnancy within 3 months of death)

Date of operation 10-
Major findings of operation:
of autopsy:

CERTIFICATION APPROVED BY
Thos. S. Morrill M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-26-48 at about noon M
(c) Where did injury occur? (Rosewood) Owens Mills (City or town) Baltimore (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Rosewood Boys Home (Specify home, farm, industrial place, public place) While at work? Yes
(e) Means of injury Accidentally knocked to floor

23. Signature J. Swan M.D. M. D.
Address Owings Mills Date signed 10-7-48

J. Swan

667485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

667485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Cliftview Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Cliftview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta E. Magness

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1910

8. AGE: Years	Months	Days	If less than one day
38	8	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William W. Magness
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Maud Blum
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. E. Magness
(b) Address 1506 Cliftview Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 OCT 9 - 1948 (Date rec'd by Registrar) (b) Huntington Pollimore, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Oct 7 1948.
and that I last saw her alive on Oct 6 1948.

Immediate cause of death: Carcinoma of breast — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Joseph Pokorny Jr. M.D.
Address 2200 E Madison St Date signed 10/8/48

667486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

832

667486

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Bayonne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AULT ELMER F

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-09-1989

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: H. Edith Ault
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) JAN. 29 - 1897

8. AGE: Years 51 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation salesman

11. Industry or business C.D. KENNY CO.

FATHER
12. Name Gustave Ault
13. Birthplace Md.

MOTHER
14. Maiden Name Fredricka Hacker (HECKER)
15. Birthplace Md.

16 (a) Informant H Edith Ault
(b) Address 3203 Bayonne Av.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location BALTIMORE

18 (a) Funeral director JOHN T. STRINGBURY
(b) Address 2300 EDMONDSON AVE.

19 (a) OCT 9 - 1948 (Date rec'd by registrar) Huntington Station, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/48 19 , at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 19 48 to 9/8 19 48, and that I last saw h[illegible] alive on 10/5/48 19

Immediate cause of death

Cardio-respiratory failure

Due to Sub-Arachnoid hemorrhage, ruptured

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Shear

Address [illegible] Date signed 9/8/48 M.D.

VS 150

G67487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Registered No. G67487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1419 S. Charles St.

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) almost 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1419 S. Charles St. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Magdalene (Lena) White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Colan White —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15, 1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	4	21		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER 12. Name Adolph Obeim

FATHER 13. Birthplace Germany —

MOTHER 14. Maiden Name Marie Eva Langhauer

MOTHER 15. Birthplace Germany —

16 (a) Informant Mrs. Catherine O'Lea (niece)

(b) Address 1419 S. Charles St., Balto. 30, Md.

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Cem —

Location Balto. Md.

18 (a) Funeral director A. Howard Evans

(b) Address 1600 S. Charles St Balto 30 Md.

19 OCT 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed., Oct. 6, 1948 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1948 to 10/6 1948 and that I last saw h[illegible] alive on 10/6 1948.

Immediate cause of death Acute cardiac failure associated with Arteriosclerotic heart disease — Duration 3 days

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Leslie

Address 126 Hanover St Date signed 10/5/48 M D

VS 150

667488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 667488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2712 Allendale Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2712 Allendale Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THELMA R. KING

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Robert W. King

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1900

8. AGE: Years: 47 Months: 11 Days: 26 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: U. S. F. & G. Co.

FATHER 12. Name: Charles E. Roberts

13. Birthplace: Dorchester Co., Md.

MOTHER 14. Maiden Name: Mary E. Insley

15. Birthplace: Dorchester Co., Md.

16 (a) Informant: Mrs. Alva Ryall

(b) Address: 2712 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) OCT 9 - 1948 (Date rec'd by Registrar) (b) Filed Oct. 11, 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1948 at 7:15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 18 1946 to Oct 6 1948 and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death: a. Pneumatic Heart b. Cardiac Hypertrophy

Duration: 6 years

Due to: Aortic Insufficiency with incompetency

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature [illegible] Address 2911 Barnard Rd. Date signed 10-8-48

VS 150

667489 J - 116473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12R

667489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 3
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Ettings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6501

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	1029	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER	12. Name	Henry Hunt
	13. Birthplace	Md.
MOTHER	14. Maiden Name	Emma Matthews
	15. Birthplace	Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jno. George A. Hallenan
(b) Address 1631 Orchid St. Baltimore, Md.

19 OCT 9 1948 Timothy Williams, M.D. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1948, at 8 PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 9 1948 to Oct. 6 1948, and that I last saw h im alive on Oct. 6, 1948

Immediate cause of death: Pulmonary tuberculosis — Duration: 7 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Gayle Burton
Address Baltimore City Hospitals Date signed 10/7/48

67490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2304 Division Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2304 Division Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME PATSY MOYLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug. 4, 1882

8. AGE: Years 66 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Smithfield, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Elijah Spradley

13. Birthplace Virginia

MOTHER 14. Maiden Name Jane Diggs

15. Birthplace Virginia

16 (a) Informant Jannie Carter

(b) Address 2304 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Family lot

Location Smithfield, Va.

18 (a) Funeral director Mrs? George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) OCT 9 1948 (Date rec'd by Registrar) Huntington Williamson Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1948 at 1:45 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 29 1948 to Oct 7 1948.

and that I last saw h alive on Oct 7 1948

Immediate cause of death Cerebral hemorrhage Duration Eight days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R Garland Schmidt

Address 1534 Druid Hill Ave Date signed Oct. 8, 1948

VS 150

67491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 67491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Washburn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME RAYMOND A. PORTER

3 (b) If veteran, name war: One

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A. Porter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19-1894

8. AGE: Years 53 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Ammunition Inspector

11. Industry or business U.S.A.

FATHER
12. Name Unknown
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant Mrs. Mary A. Porter
(b) Address 5407 E. Drive Baltimore 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month)
(c) Cemetery or crematory National
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 OCT 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 1 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intra cranial hemorrhage

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was ~~suspected~~ X or ~~undetermined~~ ☐ cause of death, fill in the following:
(a) Date of injury 10-8-48 at 11:15 P.M.
(b) Where did injury occur? Patapsco Ave. & 6th St. Brooklyn
(c) Did injury occur at home, on farm, industrial place, in public place? public
(d) Means of injury Pedestrian struck by auto.

23. Signature Emil L. Rogg M.D.
Medical Examiner
Date signed 10-9-48

667492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1112

Registered No. 667492

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Elkhurst (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 10 41st Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Albert Provot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/25

8. AGE: Years 22 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace New York City N. Y. (Town, county, and state)

10. Usual Occupation Seminarian

11. Industry or business St. Mary's Seminary

FATHER
12. Name Rudolph Provot
13. Birthplace Germany

MOTHER
14. Maiden Name Antonia Myer
15. Birthplace Germany

16 (a) Informant Gerard Neufeld
(b) Address 305 Broadway, Elmhurst N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Middle Village, L. I. N. Y.

18 (a) Funeral director H. H. Ulmers and Son
(b) Address 805 N Calvert St

19 (a) (Date received by registrar) OCT 9 1948 (b) Huntington Williams, M.D.

VS 151

2. USUAL RESIDENCE OF DECEASED: (duplicate)
(a) State [illegible] (b) County
(c) City or town Elmhurst (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 10 41st Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1948, at 5 45 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Find death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Stefinak M.D.
Medical Examiner.
Date signed Oct 8, 1948

667493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862

Registered No. 667493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Pinewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARDO ALIAMO

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-2272

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	9	1		

9. Birthplace Sicily, Italy (Town, county, and state)
10. Usual Occupation Timber Man
11. Industry or business Pipe Laying

FATHER
12. Name Phillip Alaimo
13. Birthplace Italy

MOTHER
14. Maiden Name Anna ?
15. Birthplace Italy

16 (a) Informant: Phillip Aliamo
(b) Address 4004 Pinewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road & Moravia Avenue

18 (a) Funeral director Frank Della Noce
(b) Address 322 S. High Street

OCT 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948 at 4:38 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-48 at 3:50 P. M.
(b) Where did injury occur? Northern Parkway and Chinquapin Driveway
(c) Did injury occur at home, on farm, in factory, on street, or public place? Industrial While at work? Yes
(d) Means of injury Cave-in (Laying drain pipe in trench)

23. Signature Earl Krug M.D.
Date signed 10-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. 52-6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341-Gilmor St., (St)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1341-Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Bulls.
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-6045

MEDICAL CERTIFICATION

4. Sex M. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 9-10-1900
8. AGE: Years 48 Months - Days 25 If less than one day hr min.
9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Bulls
13. Birthplace S. C.

MOTHER
14. Maiden Name Gaston
15. Birthplace S. C.

16 (a) Informant Mary Bulls
(b) Address 1341-Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location Baltimore

18 (a) Funeral director A. Hatfield
(b) Address 916 Lemmon Street

19 OCT 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

20. DATE OF DEATH 10-5-1948

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1948 to 10-5-1948 and that I last saw h[illegible] alive on 10-4-1948

Immediate cause of death (a) Cardiac (Coronary) Occlusion myocarditis
Due to Diabetes
Due to Gastritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: Few Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Boykin
Address 1133 Monroe Date signed 10/9/48

VS 190

G67495

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 44 [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Melvin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-9-09

8. AGE: Years 39 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace No. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Solomon Williams
13. Birthplace No. Carolina

MOTHER
14. Maiden Name Martha ?
15 Birthplace No.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Location Warsaw N. C.

18 (a) Funeral director A. Tolliefield
(b) Address 918 Linwood Ave.

19 [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1948 to 10/7 1948 and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death
subarachnoid hemorrhage
presumably
Due to Rupture aneurysm of basilar
Due to arteriosclerosis of circle of Willis
Other Conditions Essential hypertension, history

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: none performed

Diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(e) Means of injury

23. Signature John Collins Harvey M.D.
Address Johns Hopkins Hospital Date signed 10-8-48

VS 150

667496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1626 Ashland ave

(c) Hospital or institution: 71

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 Ashland ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ophelia Bantop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5-1897

8. AGE: Years 50 | Months 10 | Days 2 | If less than one day: hr. min.

9. Birthplace King & Queen Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Pollard

13. Birthplace King & Queen Co. Va

MOTHER 14. Maiden Name Emma Baytop

15. Birthplace King & Queen Co. Va

16 (a) Informant James C. Pollard

(b) Address 1804 N. Bouvier St. Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11-48 (month) (day) (year)

(c) Cemetery or crematory Rockley Cem.

Location Rockley Phila

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bdantley ave Huntington Middletown Md

19 (a) OCT 9 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION OCT 7-48

20. DATE OF DEATH Oct. 7th 1948, at 2 a- M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1948 to after 7 1948 and that I last saw h alive on October 2 1948.

Immediate cause of death Cerebral Hemorrhage.

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Truehart

Address 1623 E. N. Ave Date signed 10/8/48 (M/D/Y)

VS 150

667497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3329 Avondale Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3329 Avondale Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON E. LIST

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Ida List

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1879

8. AGE: Years	Months	Days	If less than one day
69	0	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Baltimore Transit Co.

FATHER

12. Name George List

13. Birthplace At Sea

MOTHER

14. Maiden Name Johanna Bailey

15 Birthplace Pa.

16 (a) Informant Mr. John F. List, brother

(b) Address 3329 Avondale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 9 - 1948 (b) Washington Wilkinson, M.D. (If dead by reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8, 1948 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1948. to Oct 7 1948, and that I last saw h(?) alive on Oct 7 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	2 mos
Due to Arteriosclerosis	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest Green M. D.

Address 101 Bryn Mawr Rd Date signed Oct 8, 1948

VS 150

BC-48-2178 ✓ 667498

667498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 667498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Fait ave # 26 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy GIBSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Oct 48

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Russel Edward GIBSON
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy Rita LASEK
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address (above)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 9 48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk ave -

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 410 E. Fayette St. Baltimore, Md.

19 (a) 10 (Corrected by registrar) (b) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1948, at 6 06 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Oct 1948 to 9 Oct 1948, and that I last saw h[illegible] alive on 9 Oct 1948

Immediate cause of death Atelectasis, Congenital — Duration 2d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis Congenital

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert K. Schoenheider M. D.
Address Maryland Gen. Hosp. Date signed 9 Oct 48

VS 150

667493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 667493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2732 N. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella M. Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/73

8. AGE: Years	Months	Days	If less than one day
74	11	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas F. Madden
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Cahill
15. Birthplace Ireland

16 (a) Informant Julia C. Madden
(b) Address 2732 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 804 N. Eutaw St. Baltimore, Md.

19 (a) 10/8 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Oct. 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 8 Oct. 1948

VS 151

67500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 82a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Norton

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sarah F. Norton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1861

8. AGE: Years	Months	Days	If less than one day
86	10	15	hr. min.

9. Birthplace Middleset, Va (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Ben Norton
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Clark
15. Birthplace Louisana

16 (a) Informant Mrs. Sarah F. Norton
(b) Address 125 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3800 Frederick Ave

18 (a) Funeral director Howard F. Bligh
(b) Address 6007 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 10 1948 Huntington Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1948 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/9 1949, and that I last saw h[im] alive on 10/8 1948.

Immediate cause of death: Cerebro vascular accident — Duration: 4 hrs

Due to: Generalized arteriosclerosis Hypertension — yrs

Due to: — yrs

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Feldman Jr M.D.
Address 817 St Paul St Date signed 10/9/48

667501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 667501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2317 Whittier Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2317 Whittier Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH GOLDFUSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Roofing Business

FATHER 12. Name Laib Mayer Goldfuss

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Unkown

MOTHER 15. Birthplace Russia

16 (a) Informant Leah Goldfuss

(b) Address 2317 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 1 (month) (day) (year)

(c) Cemetery or crematory Sharrei Tfiloh Cem

Location Windsor Hill Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) OCT 10 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 19 48 at 2 A. M

21. I certify that death occurred on the date above stated that I attended deceased from Oct 1 1948 to Oct 10 1948, and that I last saw h[illegible] alive on Oct 10 1948.

Immediate cause of death	Duration
Coronary Occlusion	3 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)

(e) Means of injury

23. Signature Irving Levinson

Address 2128 W North Ave Date signed 10/13/48

VS 15

Huntington Williams, M.D.

667502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 667502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Residence

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3302 Burleith Ave, City (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Miss Zelda Lena Lipitz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex f
5. Color or race white
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Benjamin Lipitz husband dead
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 15, 1877
8. AGE: Years 71 Months 0 Days 23 If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Hyman Glauser (D)
13. Birthplace Russia

MOTHER
14. Maiden Name Rose ? (D)
15. Birthplace Russia

16 (a) Informant daughter Mrs. Wm. Boyst
(b) Address 3302 Burleith Ave, Balt. Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1100 Eutaw Place
19 (a) (Date received by registrar) (b) Huntington Williams Registrar

OCT 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1948, at 10 08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Oct 8 1948, and that I last saw her alive on Oct 8 1948.

Immediate cause of death Generalized Carcinomatosis

Due to Ca. of Sigmoid Bowel

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 16, 1948

Major findings of operation: Metastatic Carcinoma

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John M. Dawson M.D.
Address Union Memorial Hosp Date signed 10/8/48 M D

G67503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G67503
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 C Rhoads St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lieberman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Russia (Town, county, state or country)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Benjamin Lieberman
(b) Address 3506 Springdale Ave

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew-Mtz Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eastern Pkwy

19 (a) Date received by reg. (b) Registrar

OCT 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 at 7 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1948 to 10/8 1948, and that I last saw him alive on 10/8/48 19 10 A M

Immediate cause of death
Pulmonary edema

Due to Congestive Heart Failure; Mesenteric thrombosis; Peritonitis

Due to

Other Conditions Carcinoma Rectum

(Include pregnancy within 3 months of death)

Date of operation 9/27/48

Major findings of operation: Volvulus of Sigmoid Colon & Gangrene bowel

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David V. Seltzer
Address Sinai Hospital Date signed 10/8/48

129

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

G67504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. 25504

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 5624 READY AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town).
(d) Street No. 5624 READY AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL L. BATEMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ANN BATEMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 5 1869

8. AGE: Years	Months	Days	If less than one day
79	10	3	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name SAMUEL BATEMAN
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH ROBINSON
15. Birthplace MD.

16 (a) Informant MARGARET E. BATEMAN
(b) Address 5624 READY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 11 48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO.

18 (a) Funeral director H. W. JENKINS & SONS CO.
(b) Address YORK RD. & ROSSITER AVE.

19 (a) OCT 12 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 October 1948, at 5:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3 Oct 1948 to 8 Oct 1948, and that I last saw h[illegible] alive on 8 Oct 1948.

Immediate cause of death: Myocardial failure — Duration: 1 day
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Howard [illegible] M.D.
Address 1515 N. Milton Ave Date signed 10-8-48

VS 150

G67505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G67505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Wolf Sts
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Elizabeth Boughter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	12	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm Daub
13. Birthplace Penna

MOTHER
14. Maiden Name — Schaffer
15. Birthplace Penna

16 (a) Informant Mrs Bertha H Bowman
(b) Address 1539 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Fredericksburg Penna

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 E Monument St

19 (a) OCT 12 1948 (Date rec'd by registrar) (b) Huntingtown Calvert County, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948, at 12 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 27 1948, to 10-8 1948, and that I last saw her alive on 10-8 1948.

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Arterial aneurism	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber, M. D.
Address Sinai Hosp Date signed 10-8-48

G667506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G667506
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 39 days
(e) Length of stay in Baltimore (yrs., mos., or days): 39 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Fruitland
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Box 63
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Deal, George William

3 (b) If veteran, name war: VA 1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1887

8. AGE: Years	Months	Days	If less than one day
61	2	25	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: truck laborer
11. Industry or business:

FATHER
12. Name: William Deal
13. Birthplace: unknown

MOTHER
14. Maiden Name: Hanna Wise
15. Birthplace: Snow Hill, Md.

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Fruitland, Md.

18 (a) Funeral director: James F. Stewart
(b) Address: Salisbury - Md.

19 (a) (Date rec'd by registrar) OCT 10 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1948 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1948, to Oct. 8, 1948, and that I last saw him alive on Oct. 8, 1948.

Immediate cause of death: Carcinoma of bladder, advanced — Duration: 6 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson, Clinical Director, M.D.
Address: U.S. Marine Hospital Date signed: 10/8/48

V S 150

667507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 667507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Helen Bryan
15. Birthplace Md.

16 (a) Informant Helen L. Griffin
(b) Address 1615 Harlem Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory Catonsville
Location Balto. Co.

18 (a) Funeral director Lemuel M. Sullivan
(b) Address 1011 N. Arlington Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Oct 1 1948, and that I last saw him alive on Oct 1 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Chron. Myocardial Infarction	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 10/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667508

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 Howard Ave. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertheu Riggs

3 (b) If veteran, name war	3 (c) Social Security Account No.	4 Sex	5. Color or race	6 (a) Single, married, widowed or divorced
None	None	Female	White	Widowed

6 (b) Name of husband or wife Uriah Ward Riggs 6 (c) If alive, give age dec. years

7. Birth date of deceased (mo., day, yr) 9-21-1882

8. AGE: Years	Months	Days	If less than one day
66	—	18	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER	12. Name	Daniel H. Crider (dec.)
	13. Birthplace	Pa.
MOTHER	14. Maiden Name	Mary Griggs (dec.)
	15. Birthplace	Md

16 (a) Informant William W. Riggs

(b) Address 6 Howard Ave. Catons.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md.

18 (a) Funeral director Easton Home

(b) Address 608 Frederick Ave. Caton

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 19 48 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 19 48 to 10-9 19 48.

and that I last saw her alive on 10-9 19 48.

Immediate cause of death	Duration
Cardiac failure	
Due to Acute Coronary occlusion	
Due to Arteriosclerotic c.v disease	
Other Conditions	

(include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney J. Venable Jr. M.D.

Address St Agnes Hospital Date signed 10/9/48 M. D.

VS 19)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G67509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Days, 8Hrs., 15Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 29,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Potter Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Bernard Clatterbuck Jr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/48

8. AGE: Years | Months | Days 3 | If less than one day 8 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Bernard Clatterbuck
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Hazel Krause
15. Birthplace Pikesville Md.

16 (a) Informant Mrs Ida Clatterbuck
(b) Address 35 Greenspring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Easton Bowie
(b) Address 608 Frederick Ave Catonsville

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 12:15 A.

20. DATE OF DEATH 10-9 19 48 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Pre-Mature Baby

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. S. Womack M. D.
Address Bon Secours Hosp. Date signed 10/9/48

VS 150

CERTIFICATE CORRECTED 9-1-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667510 LCH 122441 — Registered No. 667510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Calverton
(d) Street No. 2319 Cloverton Hghts. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KRATZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/21/1870

8. AGE: Years	Months	Days	If less than one day
78	9	16	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ? Weaver
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Brown
15. Birthplace Md.

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Towell
(b) Address 1427 Edmondson Ave (Huntington Williams Co)

19 (a) 10/4/48 (Date rec'd by registrar) (b) Registrar 10/9/48

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/48 19 at 1:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/48 19 to 10/7/48 19, and that I last saw her alive on 10/7/48 19

Immediate cause of death	Duration
Acute Cardiac failure	1 min.
Due to probable Myocardial infarction	8 days.
Due to	
Other Conditions: Fracture rt. hip	6 weeks

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-26-48 at 10:50 AM
(c) Where did injury occur? 2319 Calverton Hghts Ave (City or town) Calverton (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury: fall & floor w/ broken hip

23. Signature John L. Rich M. D.
Address Balto City Hosp. Date signed 10-7-48

V8 190

Approved by J. Julian Md

G67511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G67511
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 W. Lexington St
(c) Hospital or institution:

19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 W Lexington St
(If rural give location)
20
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berry Lee Bloxom

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
male	white	~~Sa~~

6 (b) Name of ~~husband~~ or wife Lannie Bloxom
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr) May 21 - 1865

8. AGE: Years	Months	Days	If less than one day
85	4	18	hr. min.

9. Birthplace Bloxom Va.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Berry Bloxom
13. Birthplace Onancock Va.

MOTHER
14. Maiden Name Burnette Bloxom
15 Birthplace Va.

16 (a) Informant Mrs. E. L. Bloxom
(b) Address 1322 W. Lexington St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Bethel Baptist Church
Location Bloxom, VA.

18 (a) Funeral director Wm. J. Ticknor & Sons.
(b) Address Balto. Md.
Huntington Millionaire, Md

10 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 9 - 1948, at 7:00 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 5-17-1948, to 10-9-1948, and that I last saw h~~im~~ alive on 10-2-1948.

Immediate cause of death	Duration
Organic Heart Disease	unknown
Due to	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Ruland, M. D.
Address 2532 Edmondson Ave Date signed 10-9-48.

VS 150

667512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

667512 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edmondson Ave. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAISY W. BAILEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George W. Bailey
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Sarah Fite
15. Birthplace Unknown

16 (a) Informant Mrs. W. G. Bailey
(b) Address Route 5 Box 214 Woodlawn 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11 48 (month) (day) (year)
(c) Cemetery ~~Lutheran~~ Wards Chapel
Location Baltimore County, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) OCT 10 1948 (b) Washington Millhouse, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1948 to OCT. 8 1948, and that I last saw HER alive on OCT. 8 1948

Immediate cause of death: ARTERIOSCLEROSIS — Duration: ??

Due to

Due to

Other Conditions: SECONDARY ANEMIA — Duration: 3 MOS.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stuart D. Sudler M. D.
Address 201 E. 33rd St. Date signed 10/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

667513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Egerton Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Egerton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA MAY McLAUGHLIN

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	13 14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Robert McLaughlin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rebecca E. [illegible]dden
15. Birthplace Baltimore

16 (a) Informant Mrs. Robert M. Scheck
(b) Address 507 Yarmouth Rd., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

OCT 20 1948 (b)
(Date rec'd by registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948, to Oct 8 1948, and that I last saw h[illegible] alive on Oct 8th 1948

Immediate cause of death	Duration
Acute Cardiac Asthenia	1/2 hour
Due to Coronary Thrombosis	9 days
Due to Hypertension	9 days
Other Conditions Arterial Sclerosis	2 years

(Include pregnancy within 3 months of death)

Date of operation --
Major findings of operation: --

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert E. Tepe M. D.
Address 3400 Windsor Ave Date signed 10/9/48

Funeralizer for Philadelphia Hot

BC-48-2022
667514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

667514 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Kennit Ct. (If rural give location)
(e) Citizen of foreign country? No, Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Adams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-3-48

8. AGE: Years 0 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lester Adams

13 Birthplace Williamstown, Pa.

MOTHER 14. Maiden Name Catherine Bowman

15 Birthplace Williamstown, Pa.

16 (a) Informant Lester Adams

(b) Address 2431 Kennit Ct #3

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)

(c) Cemetery or crematory Williamstown Pa.

Location

18 (a) Funeral director Ellsworth Armacost

(b) Address 3911 Liberty Heights Ave

19 (a) 10 1948 (b) Lexington Filed rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948 at 4 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1948 to Oct 8 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death: Cardio-Resp. failure — Duration

Due to: Prematurity

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature David Reed

Address Univ. Hosp. Date signed 10/9/48 M. D.

VS 150

G67515 ✓ G67515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 313 Calhoun Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 313 Calhoun Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret A. McElreavy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 8 1 1857

8. AGE: Years	Months	Days	If less than one day
91	2	7	hr min

9. Birthplace England

(Town, county, and state)

10. Usual Occupation

11. Industry or business Home - Duties

MOTHER / FATHER

12. Name Father, Mc Elreavy

13. Birthplace Ireland

14. Maiden Name Jupiter Murphy

15. Birthplace Ireland

16 (a) Informant Miss Lydia C. McElra.

(b) Address 313 S. Calhoun Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Old Loudenschlager

18 (a) Funeral director Lakey Bros.

(b) Address 1318 Light St.

(a) (b)

Date received (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 2 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 6-4 1938, to 10-8 1948, and that I last saw her alive on 10-7 1948.

Immediate cause of death Arteriosclerosis Chr. card. vascular disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H Edmund Lewis

Address 3400 Hilton Rd Date signed 10/9/48

667516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667516 Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Virginia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Garret
(c) City or town Grace Frederick (If outside city or town limits, write RFD and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olivia M. Bowen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	W.

6 (b) Name of husband or wife J. Edward Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	0	18	17	

9. Birthplace Roland Grove, Garret Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Thomas Morgan
13. Birthplace Roland Grove, Md.

MOTHER
14. Maiden Name Regina Thomas
15. Birthplace Maryland.

16 (a) Informant: Mrs. Ida L. Bowen
(b) Address 3320 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Lutheran Methodist Church
Location Barnstown, Maryland.

18 (a) Funeral director Young (Address)
(b) Address 3705 Park Heights Ave

OCT 11 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948, at 6 P. M

21. I certify that death occurred on the date above stated that I attended deceased from June 1 1948 to Oct 9 1948 and that I last saw her alive on Oct 9 1948

	Duration
Immediate cause of death	
Uraemia	7 days.
Due to Hypertensive Cardio Vascular Renal disease.	2 yrs.
Due to Arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Milton E. Lowman M. D.
Address 4643 Park Heights Ave Date signed 10/10/48
Oct. 10, 1948

667517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667517

AE-122751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 820 [redacted] HOLLINS (St.) (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Steinbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. [redacted]

6 (b) Name of husband or wife: Lillian Mills Steinbach

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr April 12-1887

8. AGE: Years 61 | Months 5 | Days 25 | If less than one day hr min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Truck helper

11. Industry or business, Self-employed

FATHER

12. Name Charles Steinbach (D

13. Birthplace Germany

MOTHER

14. Maiden Name Mary McGary (D

15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11 '48 (month) (day) (year)

(c) Cemetery or crematory Mew Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Krause Funeral Home

(b) Address 216 S. Charles St.

19 OCT 11 1948 Huntington Williams M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7. 1948 at 11.50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6- 1948 to 10-7 1948. and that I last saw him alive on 10-7 1948

Immediate cause of death Bilateral Pulmonary Tuberculosis — Duration 4½ mos

Due to

Due to

Other Conditions Malnutrition. Syphilis

(If female, pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Frank M. Shipley

Address Balto City Hosp. Date signed Oct. 12, '48

VS 153

12 12

G67518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

Registered No. G67518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 242 Mallow Hill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Mallow Hill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer F. Orr

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Lola M. Orr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1875

8. AGE: Years 73 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation Retired Insurance Agent
11. Industry or business Prudential Insurance Co.

FATHER
12. Name David F. Orr
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn M. ?
15. Birthplace Maryland

16 (a) Informant Mr. William F. Orr
(b) Address Route 14, Box 322, Baltimore-20, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Pomeroy
(b) Address 1003 E. Baltimore St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 7 1948 to Oct 8 1948, and that I last saw him alive on Oct 7 1948

Immediate cause of death: Myocarditis — Duration: sudden

Due to: Arteriosclerosis

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans Zinsser M. D.
Address 4012 Edmondson Ave. Date signed

G67519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67519 ✓ Registered No. 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giovanna Maria Fava

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Maria
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1876

8. AGE: Years	Months	Days	If less than one day
72	8	24	hr. min.

9. Birthplace Italy (Town, county and state)
10. General Occupation Fava Fruit Co Dealer
11. Name of employer Wine Co

FATHER
12. Name Andrew Fava
13. Birthplace Italy

MOTHER
14. Maiden Name Nicoletta Limino
15. Birthplace Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
Cemetery Mausoleum Lorain
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948 at 1 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 48 to 10/10 19 48
and that I last saw h alive on 19

Immediate cause of death: Cirrhosis of Liver
Primary hepatoma

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Norman E Shamen M.D.
Address Johns Hopkins Hospital Date signed 10-10-48

667520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 667520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Broadway (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Beatrice Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-1-93

8. AGE: Years 55 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name George Stein
13. Birthplace Russia

MOTHER 14. Maiden Name Betty
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948, at 7 a.m. 45

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 9 1948.
and that I last saw h[illegible] alive on Oct 9 1948.

Immediate cause of death: Auricular fibrillation
Due to: Pulmonary edema
Due to: interstitial and hypertensive heart disease.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 day. / days / years

Date of operation —
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address J. H. H. Date signed 10-9-48

G67521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. G67521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 Harlem
(c) Hospital or institution: at Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Harlem Ave (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Rosalie Lee

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Yellow | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lee Quong
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) Oct-28-1894

8. AGE: (53) Years 54 | Months 11 | Days 10 11 | If less than one day: hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Not Known
13. Birthplace China

MOTHER
14. Maiden Name Not Known
15. Birthplace China

16 (a) Informant Mrs. William Lee
(b) Address 1435 E. Baltimore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W. North Ave, City #1.

19 OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11- 1948, to 10-8 1948, and that I last saw h[illegible] alive on 10-8 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Ruland, M. D.
Address 2532 Edmondson Ave Date signed 10-9-48

VS 150

G67522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4416 Roland Ave
(c) Hospital or institution: at home 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Milton Painter Hill

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louisa B. Hill
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Sept 18 1884

8. AGE: Years: 64 | Months: 0 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Physician
11. Industry or business: Medicine

FATHER
12. Name: Dr Chas G Hill
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Mabel Painter
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs Louisa B. Hill wife
(b) Address: 4416 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory: St Thomas'
Location: Jamaica Forest

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. Mowen Sec.) 100 W. North Avenue

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral to Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1948, at 2.30 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from January 1948 to Oct 8 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William S Kelly M.D.
Address: 4006 Roland Ave Date signed: Oct 9, 1948

G67523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83D

Registered No. G67523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6313 Weidner Ave.

(c) Hospital or institution: Edgewood Nursing Home 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6313 Meudner ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME McGINNISS, Mrs. Esther McGinniss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William R. McGinniss

6 (c) If alive, give age About 65 years

7. Birth date of deceased (mo., day, yr.) June - 8 - 1868

8. AGE: Years	Months	Days	If less than one day
80	4	21	hr. min.

9. Birthplace Baltimore ? Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Uriah J. Bottomore

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Mary Louise Tregler

15. Birthplace Baltimore, Md.

16 (a) Informant Miss Katherine Bottomore

(b) Address 6313 Weidner Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)

(c) Cemetery or crematory Presbyterian (Govans)

Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108 West North Ave. Balto. Md.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 1948 at 6-40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Oct 9 1948, and that I last saw him alive on Sept 30 1948.

Immediate cause of death Intestinal Hemorrhage — Duration 15 min.

Due to Intestinal Lesion undetermined.

Due to

Other Conditions Hemiplegia — 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Williams M.D.

Address 6710 York Rd Date signed Oct 9th 1948

VS 150

123

G67524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gracie Osborn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/23/1881

8. AGE: Years 66 | Months 11 | Days 6 | If less than one day 15 hr. min.

9. Birthplace Marion Ala (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Bradford Clemons
13. Birthplace Ala.

MOTHER
14. Maiden Name Sallie Mart
15. Birthplace Ala

16 (a) Informant Thomas J Clemons
(b) Address 121 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

OCT 11 1948 (c) (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/48 19 at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1948 to Oct. 7 1948 and that I last saw h[illegible] alive on Oct. 7 19 48.

Immediate cause of death Chronic Myocarditis | Duration 6 months
Due to Chronic Interstitial
Due to Nephritis | 6 months
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1038 Sharp St Date signed 10/11/48

VS 150

X

G667525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G667525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.oa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. BETHEA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
29			hr. min

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Neal E. Bethea
13. Birthplace S. C.

MOTHER
14. Maiden Name Bertha Campbell
15. Birthplace S. C

16 (a) Informant Pender Campbell
(b) Address 306 N. Fremont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month)
(c) Cemetery or crematory Dillon S. C.
Location S. C.

18 (a) Funeral director George B. Nelson
(b) Address 1303 Presstman ST

19 OCT 11 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948, at 5 12 p. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd & 3rd ° Burns of 50 % of body

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10- 8 -48 at Approx. 5 P. M.
(b) Where did injury occur? 936 Madison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Room afire

23. Signature Emil L Rzy M.D.
Medical Examiner.
Date signed 10-9-48

VS 151

X

667526

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 667526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 680 Josephine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Tilghman

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Isaac Tilghman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Nov. 25, 1894

8. AGE: Years 49 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace: md (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant: Ida Tilghman
(b) Address: 680 Josephine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: md

18 (a) Funeral director: George B. Nelson
(b) Address: 1303 Priestman St

19 OCT 11 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7- 1948 at 5:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948, to 10-7 1948, and that I last saw h[illegible] alive on 10-1 1948.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

CERTIFICATION APPROVED BY
[illegible], M.D.
for H. R. Davis, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Black M. D.
Address Provident Hosp Date signed 10-12-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50

LEH 122946

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Cherry Hill Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1899

8. AGE: Years	Months	Days	If less than one day
49	1	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dallas Clayborn
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Davis
15. Birthplace Va.

16 (a) Informant Records of Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Balto nat mal
Location

18 (a) Funeral director George S. Valsom
(b) Address 1303 Presstman St

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Tuntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/48 19 at 12:35 PM

21. I certify that death occurred on the date above stated: that I attended deceased from 9/14/48 19 to 10/7/48 19, and that I last saw her alive on 10/7/48 19

Immediate cause of death: (a) Cerebral Carcinomatosis. Duration 2 yrs.

Due to Carcinoma of the breast

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Leglin
Address BCH Date signed 10-7-48

VS 150

Leglin X

667528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

Registered No. 667528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1501 Battery Ave

(c) Hospital or institution:

24-41

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1501 Battery Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thelma E. Wicklein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife John N.

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 25, 1909

8. AGE: Years	Months	Days	If less than one day
39	2	12	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Wilbur Wagner

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Mary Hamilton Funk

MOTHER 15. Birthplace Md

16 (a) Informant Mrs Mary Wicklein

(b) Address 1501 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Washington Blvd

18 (a) Funeral director John F Henry Inc

(b) Address 715 Light St

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 6 1948 and that I last saw her alive on Oct 6 1948.

Immediate cause of death	Duration
Acute pulmonary Edema	3 hrs
Due to Chronic Cardiac Dilation	1 yr
Due to Arteriosclerotic Cardiovascular Disease	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 2704 Eutaw Blvd Date signed Oct 11 1948

VS 150

667529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

Registered No. 667529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun st
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (Govans)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4619 Ridgeway Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Rudiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gustavus Rudiger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1879

8. AGE: Years 69 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Wiseman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Balto Md

16 (a) Informant Mr. Gustavus Rudiger
(b) Address 4619 Ridgeway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Leasure Funeral Home
(b) Address 7401 Belair Rd.

OCT 11 1948 (b) [illegible]
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1948, at 6:39 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1948, to 9 Oct 1948, and that I last saw her alive on 9 Oct 1948.

Immediate cause of death Cachexia — Duration

Due to Carcinoma of rt. lung with

Due to generalized metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Carcinoma rt. lung

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent A. Cacace M. D.

Address Franklin Square Hosp. Date signed 10 Oct 48

667530 48-20933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

667530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Montford (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Richard Ward

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 29/48

8. AGE: Years 0 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Benjamin S. Ward
13. Birthplace Baltimore

MOTHER 14. Maiden Name Ethel Schwartzkopf
15. Birthplace Baltimore

16 (a) Informant Mr. Benj. S. Ward
(b) Address 700 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 12 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2524 Orleans St

19 OCT 11 1948 (Date filed by Registrar) (b) Huntingtown, Calvert, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/48 1948 at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/10 1948. and that I last saw him alive on 10/10 1948

	Duration
Immediate cause of death: Circulatory Collapse	
Due to: Sclerema	
Due to:	
Other Conditions: (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Aponte M.D.
Address Mercy Hosp. Date signed 10/11/48

667531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

667531 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 - Division St.

(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RERAL and give town)

(d) Street No. 1727 - Madison Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Birdie Lewis Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife William Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1893

8. AGE: Years	Months	Days	If less than one day
55	1	23	hr. min.

9. Birthplace Matthews, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant William Brown

(b) Address 1727 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Mt Auburn

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna Ave

19 (a) Huntington Milligan, M.D. (b)

OCT 11 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 6 45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-8 1948, and that I last saw her alive on 10-5- 1948

Immediate cause of death	Duration
Cerebral Vascular accident probably thrombosis	
Due to Hypertension	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Brady, M. D.

Address Provident Hosp Date signed 10-9-48

VS 150

G675332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G675332
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Washington Street
(c) Hospital or institution:
Home 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Merriken

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-14-0258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name [redacted] wife Helena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec, 18-1884

8. AGE: Years	Months	Days	If less than one day
63	9	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Merriken
13. Birthplace Md.

MOTHER
14. Maiden Name Mary T. Gipprich
15. Birthplace Md ?

16 (c) Informant Francis Merriken
(b) Address 324 S. Lehigh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery [redacted] Holy Rosary
Location Baltimore Co, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 1948, at 10:55 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948, to Oct 10 1948, and that I last saw h[redacted] alive on Oct 9 1948.

Immediate cause of death	Duration
Cerebral Softening	?
Due to Cerebral Thrombosis	
Due to Generalized Arteriosclerosis	
Other Conditions Acute Cerebral Rt. hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Leonard Bull M.D.
Address 1221 N. Luzerne Ave Date signed Oct 11 1948

8212

667533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3511 E. Fayette St
(c) Hospital or institution: 26+4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 E. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Poos Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of ~~husband~~ or wife Bertha B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1884

8. AGE: Years 64 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER 12. Name John Poos Jr

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Mrs Bertha Poos

(b) Address 3511 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11th 1948 (month), (day), (year)

(c) Cemetery or ~~crematory~~ Loudon Park

Location Fredrick Road

18 (a) Funeral director Leo G. Cook

(b) Address 1201-03 N. Patterson Park Ave

OCT 11 1948 (Date rec'd by registrar) Funeral Arrangements by Huntington Williams Co

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1948, at 5-20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Arteriosclerotic Cardiac Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. C. Schmidt M.D. Medical Examiner

Date signed 10/7/48

G67534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. G67534

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 E. Federal St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Mirschberger

3 (b) If veteran, name war | 3 (c) Social Security Account No. 215-10-7731

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene E. Mirschberger
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) 4-6-1873

8. AGE: Years	Months	Days	If less than one day
70	6	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name John P. Mirschberger
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Catherine Foltz
15. Birthplace Germany

16 (a) Informant Irene E. Mirschberger
(b) Address 2403 E. Federal St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Jos. Catholic
Location Old Fulton Road

18 (a) Funeral director The C. Dudley Fee
(b) Address 2436 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-1948 at M

21. I certify that death occurred on the date above stated: that I attended deceased from 12 Nov 1947 to 9 Oct 1948.
and that I last saw h him alive on 9 Oct 1948.

Immediate cause of death Myocardial failure — Duration 10 day
Due to Hypertension
Due to Arteriosclerosis
Other Conditions Edema, Dyspnea
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Fortune, M.D.
Address 1513 N. Monroe Date signed 11 Oct 48

VS 150

97

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G67535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Cooke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife: Aubrey L. Cooke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-15-1914

8. AGE: Years 34 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Restaurant Owner

11. Industry or business

FATHER
12. Name Albert Clarke
13. Birthplace Md

MOTHER
14. Maiden Name Mary Franke
15. Birthplace Md

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Ave
Location Mt Royal Ave & Mosher St

18 (a) Funeral director Jos E Oliver & Sons Inc
(b) Address 2435 Huntington Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Oct 8, 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5, 1948, to Oct 8 1948 and that I last saw her alive on Oct 8 1948.

Immediate cause of death Undetermined — Duration

Due to Laennec's Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Norman E Shaner, M.D.
Address Johns Hopkins Hospital Date signed 10-8-48

VS 150

G67536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G67536
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 52 E. Hill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 52 E. Hill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Longo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife Joseph Longo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 - 1888

8. AGE: Years	Months	Days	If less than one day
60 (60)	9	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Marsiglia
13. Birthplace Italy

MOTHER
14. Maiden Name Maie Zito
15. Birthplace Italy

16 (a) Informant Mary Seppi
(b) Address 1256 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Road

18 (a) Funeral director Joseph Fanaredes
(b) Address 2013 Greenmount Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31, 1938 to Oct. 9, 1948, and that I last saw h alive on Oct. 6, 1948.

Immediate cause of death Hypertensive Cardio-Vascular disease Mit Cardiac Hypertrophy and Dilatation Auricular Fibrillation — Duration 10 yrs. 3 days

Due to

Other Conditions Renal Tuberculosis — Duration 10 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Longenecker M. D.
Address Medical Arts Bldg. Date signed 10/11/48

VS 150

939

67537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 67537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Liberto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Liberto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1877

8. AGE: Years	Months	Days	If less than one day
71	4	25	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pietro Danna
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-1948 (month) (day) (year)
(c) Cemetery or crematory Mary Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director Joseph Fanaro Inc
(b) Address 2013 Fremmont Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Number on Physician's Certificate 61

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1948, at 11:50 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct. 6 1948 to Oct 8 1948, and that I last saw her alive on Oct. 8 1948.

Immediate cause of death	Duration
Cerebro-vascular accident	3 days
Due to	
Due to	
Other Conditions: Generalized arteriosclerosis Probable diabetes mellitus.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature T. Siwinski
Address Mercy Hosp. Date signed 10/14/48 M. D.

VS 150

83a

167538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 167538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home For Incurables 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life ~~11 yrs.~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss May Florence Gelletly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25 - 1886

8. AGE: Years 62 | Months 4 | Days 14 1/6 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Secretary (Painter)

11. Industry or business

FATHER
12. Name J. F. Gelletly
13. Birthplace Scotland

MOTHER
14. Maiden Name Emma M. Levette
15. Birthplace London, England

16 (a) Informant Charlotte Ettermann
(b) Address Home for Incurables (records)

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948, at 9:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1948 to 10/10 1948, and that I last saw h[illegible] alive on 10/9 1948

Immediate cause of death Metastatic Carcinoma to the brain — Duration 2 months

Due to Carcinoma of Right Breast — Duration 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 8, 1948

Major findings of operation: Primary Carcinoma of Right Breast.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work.?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hesperger, M. D.
Address 214 Medical Arts Bldg. Date signed 10/10/48

X

VS 150

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

G67539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G67539
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Hazelwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Leeds Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida Christina Welden
3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife Wm. Thomas Welden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 12/8/1874

8. AGE: Years 23 | Months 10 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, County, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Stahl (dec)
13. Birthplace Hanover Pa

MOTHER
14. Maiden Name Christina Minkel (dec)
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary W. Hemberger
(b) Address 1505 Leeds Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948 to 10-9 1948.
and that I last saw h alive on 10-7 1948.

Immediate cause of death Cardio resp failure — Duration
Due to Arteriosclerotic - C-V renal disease
Due to, or as a terminal uremia
Other Conditions Lobar pneumonia
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney J. Venable Jr MD M. D.
Address St. Agnes Hospital Date signed 10/9/48

Sidney J. Venables 121 a

VS 150

WHITE PAPER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67540
Registered No.

GM. 122679

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside City or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington ST. Nursing Home
formerly of 831 Sucaw St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11- 1862

8. AGE: Years	Months	Days	If less than one day
86	0	26	hr. min.

9. Birthplace MD.
(Town, county, or state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Dorsey (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Carr
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catheiral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

To Be Approved By Med. Examiner.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10- 7- 1948 at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 3- 1948 to 10- 7- 1948.
and that I last saw her alive on 10- 7- 1948

Immediate cause of death Cerebro vascular accident — Duration 1 wk
Due to Broncho - Pneumonia
Due to
Other Conditions Intertrochanteric fracture of femur. — Duration 6 wks
(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY
Howard J. Hawkins M.D.
For C. J. Lubinski M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Date of operation 9/15/48
Major findings of operation: Fracture femur
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ 12/2
(b) Date of occurrence 25 Aug. at M
(c) Where did injury occur? Balto. (City or town) Balto. (County) Md. (State)
1324 W. Lexington St.
(d) Did injury occur about home, on farm, in industrial place, in public place? On Street (Specify type of place) While at work? no
(e) Means of injury Fell while walking

23. Signature C. Williams M.D.
Address Balto. City Hosp. Date signed 10/7/48

667541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

667541

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 Mc Culloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Mc Culloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beauford Hector Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nannie Jones.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12, 1878

8. AGE: Years 70 | Months - | Days 26 | If less than one day: hr. min.

9. Birthplace Perry, Ga.. (town, county, and state)

10. Usual Occupation Retired Pullman Porter

11. Industry or business

FATHER 12. Name John Wilson Jones.
13. Birthplace Ga..

MOTHER 14. Maiden Name Margaret Bass.
15 Birthplace Ga.

16 (a) Informant Nannie Mitchell.
(b) Address 1836 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 11, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 8 1948. at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1948. to 10-8 1948. and that I last saw him alive on 10-8 1948.

Immediate cause of death	Duration
Myocardial Degeneration	1 mo.
Due to	
Due to	
Other Conditions Fell 3 wks ago Hemiplegia.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Ronald Murphy M. D.
Address 1547 Bloom St Date signed 10/9/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. - Every item of information should be carefully supplied. TYPEWRITER, WITH UNFADING INK.

VS 150

G67542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G67542

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 W. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Jenkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Lillie Jenkins.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 30, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	9	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Jenkins
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Md.

16 (a) Informant Lillie Jenkins.
(b) Address 828 W. Franklin St

47 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 4 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1948 to Oct 8 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death Pulmonary edema, Acute Congestive Heart Failure (Ct) — Duration approx. 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Garland Chinault
Address 902 W Franklin St Date signed 10-10-48 M D

X

VS 199

CAUTION—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667543 (163H)

~~537543~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 8207 Dundalk Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES LEROY McCORMICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen V. Dembeck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1912

8. AGE: Years 36 | Months 2 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James P. McCormick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella L. Long
15. Birthplace Balto. Md.

16 (a) Informant: Wife
(b) Address 8207 Dundalk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (Burial)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N. Broadway

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Illuminating gas

Due to

Other Conditions Mental Despondency
(Include pregnancy within three months of death)

22. If an external cause was [ ] accident [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 10-8-48 at Approx. 2:25 P. M.
(b) Where did injury occur? 8221 Dundalk Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Inhalation of illum. gas (4 burners of gas range on unlit gas heater on but unlit

23. Signature Medical Examiner. M.D.
Date signed 10-9-48

Please write plainly, with indelible ink. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667544 DC. 658817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122a

667544 Registered No.

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Mountman Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN AMPREY

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife ---

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) October 9, 1946

8. AGE: Years 1 | Months 23 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Amprey
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Marion Jackson
15. Birthplace Mafyland

16 (a) Informant: Records
(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary
Location Brooklyn

18 (a) Funeral director Joseph Russ
(b) Address 12 [illegible] Mc [illegible] St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948 at 12:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory failure due to administration of anesthesia

Due to

Other Conditions hernioplasty
Thoractotomy
(Include pregnancy within three months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-48 at 11:45 A. M.
(b) Where did injury occur? Johns Hopkins Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? hospital (Specify) No
(d) Means of injury Died on operating table-- cyclopropane with ether

23. Signature [signature] M.D.
Medical Examiner.
Date signed 10-9-48

VS 151

667545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

667545 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Lyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ramey Harry M. (Harry M. Ramey)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-9858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Sallie Zea Ramey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 23, 1874

8. AGE: Years	Months	Days	If less than one day
74	7	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation retired Banker
11. Industry or business

FATHER
12. Name James Madison Ramey
13. Birthplace Va.

MOTHER
14. Maiden Name Christie Ann Funk
15. Birthplace Md.

16 (a) Informant: Edward J. Ramey
(b) Address 3603 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave, Baltimore, Md

19 (Date received by Registrar) OCT 11 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948 at 6 45p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Oct 9 1948, and that I last saw him alive on Oct 9 19 48

Immediate cause of death	Duration
Gastro-intestinal Hemorrhage, Massive	
Due to Duodenal + gastric ulcer	
Due to	
Other Conditions Rheumatic C. Disease B.P.H.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hemorrhagic cardiac enlargement, arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature Jos Shear
Address Univ. Hosp. Date signed 9 Oct 48

Joseph Shear X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR TYPEWRITE IN INDELIBLE INK.

667546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667546

LCH 121322

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 84 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 110 Chapel Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MaryRose

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/25/1888

8. AGE: Years	Months	Days	If less than one day
59	10	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Valentine Schwieger

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Dunnigan

MOTHER 15. Birthplace Maryland

16 (a) Informant Records of Balto. City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus cemetery

Location Mt. Dundalk Ave. Baltimore

18 (a) Funeral director Lilly & Zeiler, Inc.

(b) Address 403 South Wolfe St. Baltimore

OCT 11 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

STATE

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 . at 0935 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1948 to 10/8 19 48.

and that I last saw her alive on Oct 8 19 48.

Immediate cause of death: Resp + Cardiac failure

Due to Ant. Sol. C.V. Disease + Brain edema

Due to Post Fem. Fracture

Other Conditions Diabetes Mellitus Hypertension Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 10-6-48

Major findings of operation: Arteriosclerosis Cardiovascular Disease

of autopsy: Arteriosclerosis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ernest T. Maxwell M.D.

Address 611 Fidelity Bldg. Date signed 10/6

Dr. Thomas White

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

Registered No. 667547

667547

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 338 East 22nd Stre
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 East 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HUGH FRANCIS COYLE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Harrietta M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Steamship Co.

FATHER
12. Name Bernard Coyle
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Cole
15. Birthplace Pa.

16 (a) Informant Mrs. Harrietta M. Coyle
(b) Address 338 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22nd ST.

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 at 6.30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8 years 1943 to 10/8 1948 and that I last saw him alive on 10/7 1948

Immediate cause of death	Duration
Myocardial infarction	2 days
Due to Coronal Thrombosis Arteriosclerosis	5 yrs
Due to Carcinoma Prostate Prostatectomy	5 yrs
Other Conditions	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23) Signature Thomas F White M. D.
Address 522 E 22nd St Date signed 10/9/48

VS 150

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. WRITE PLAINLY, WITH UNFADING INK.

Va 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 467548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Hacks Neck (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Read
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-2-05

8. AGE: Years 43 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Writer
11. Industry or business

FATHER
12. Name James Rogers Read
13. Birthplace Md

MOTHER
14. Maiden Name Lillie Collins
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT Cem. City
Location

18 (a) Funeral director WIEDEFELD
(b) Address GREENMOUNT AVE & 22nd ST.

19 (Date rec'd) (Signature) Huntington Williams, Registrar

OCT 11 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948 to 10-8 1948, and that I last saw him alive on 10-8 1948.

Immediate cause of death: Carcinoma of pancreas — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John Grant Wilmer M D
Address Johns Hopkins Date signed Oct 8, 48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 67549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 CHAPEL GATE LANE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 CHAPEL GATE LANE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MADALINE DI GRISTINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife CARMELO DIGRISTINE
6 (c) If alive, give age Dec years

7. Birth date of deceased (mo., day, yr) DEC. 5 1887

8. AGE: Years	Months	Days	If less than one day
60	10	3	hr. min.

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry/or business AT HOME

FATHER
12. Name JOSEPH JARDINIA
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant MRS. THOMAS FARRAR
(b) Address 16 N. KOSSUTH STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 12/48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MARYLAND

18 (a) Funeral director F.P.WIPPERT & SON
(b) Address 1300 EUTAW PLACE. 17

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williamson M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH OCTOBER 18th 1948 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1948 to 10/18 1948.
and that I last saw her alive on 10/8 1948.

Immediate cause of death: Acute Cardiac Collapse — Duration: 1 hr
Due to: Diabetic Retinitis — Duration: yrs
Due to: Hypertension Cardiovascular — Duration: yrs
Other Conditions: Senile
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1 WASHINGTON BLVD Date signed

VS 133

667550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 667550

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway and Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 167 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie J. Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George William Braun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 4, 1898

8. AGE: Years	Months	Days	If less than one day
50	10	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fortifer
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Eckert
15. Birthplace Maryland

16 (a) Informant Hazel Anderson
(b) Address Church Home and Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 Oct. 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director C. B. Shipley & Son
(b) Address 1300 Eutaw Place

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1948 to Oct. 8 1948, and that I last saw her alive on 10-8 1948.

Immediate cause of death	Duration
Cardiac failure - atrophy of pancreas - Diabetes mellitus	
Due to Arteriosclerosis	
Due to Bilateral pleural effusion	
Other Conditions.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Church Home Date signed 10/8/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK.

G67551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G67551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 OTTAWA AVE.
(c) Hospital or institution: ********** 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE. .MORRELL PARK (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 OTTAWA AVE (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME BASIL M. HILTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MIRIAM HILTON
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr) MARCH 19-1862

8. AGE: Years	Months	Days	If less than one day
86	6	18	hr. min.

9. Birthplace ELLICOTT CITY Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES C. HILTON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SARAH MULLINEAUX
15. Birthplace MARYLAND

16 (a) Informant MRS. JOHN XYLANDER
(b) Address 4226 FALLS ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 OCT. 48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Thurlington for Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 7TH. 1948 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Oct 1948 to 7 Oct 1948. and that I last saw him alive on 7 Oct 1948.

Immediate cause of death: Cardiac failure and decompensation — Duration: Indefinite
Due to Arteriosclerosis and hypertensive cardio vascular disease
Due to (marasmus)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil W Henning M.D.
Address 4580 Edmondson Ave Date signed 10 Oct 48.

VS 150

X

667552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

667552 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E. West St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha F. Sachuk

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife Pawel Sachuk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10. 1889

8. AGE: Years	Months	Days	If less than one day
59	7	29	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Grudska
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Pawel Sachuk
(b) Address 24 E. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. Location G. G. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948. at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1948. to Oct. 9, 1948. and that I last saw [illegible] alive on Oct. 7, 1948.

Immediate cause of death: arteriosclerotic Heart Disease — Duration
Due to
Due to
Other Conditions: Hemiplegia, edema. —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. R. Friedman, M.D.
Address 1319 Light St. Date signed 10/11/48

VS 153

G67553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G67553
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 E. Pratt. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Markiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 26 - 1870

8. AGE: Years: 78 | Months: 8 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Rulewicz
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary
15. Birthplace: Poland

16 (a) Informant: Cecilia Markiewicz
(b) Address: 2223 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 14-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: A. A. Co.

18 (a) Funeral director: Wm. S. Fialkowski
(b) Address: 2007 Eastern ave

19 (a) OCT 11 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 10 19 48 at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 29 19 48 to OCT. 10 19 48 and that I last saw her alive on OCT. 10 19 48.

Immediate cause of death: CORONARY Occlusion — Duration: 10/10/48

Due to: ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE ???

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: J. F. Delaney M.D.

Address 209 E. Eager St Date signed 10/11/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G67554 91382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12

Registered No. G67554

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 W. 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Marie Clatterbuck

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Arbra W. Clatterbuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1915

8. AGE: Years	Months	Days	If less than one day
32	11	26	hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Gover McCartin
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Ethel Burgee
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 11 1948 (Date rec'd by registrar) Lentington Holloway, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 11.30 Am

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945 to Oct. 10 1948. and that I last saw her alive on Oct. 10 1948

Immediate cause of death	Duration
Far advanced bilateral pulmonary tuberculosis with cavitation	3 yr. 9 mo.
Due to Obliterative pleurisy bilateral with organized	2 years
Due to Emphysema right	
Other Conditions Hepatomegaly. Splenomegaly & large kidneys ? due to amyloidosis	6 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Margaret A Morgan M. D
Address Baltimore City Date signed 10-12-48

VS 155

667555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 FALLS Rd. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME ROY CALVIN DERRY.
3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-01-1181

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: MRS JULIA DERRY.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) APRIL 14th 1889

8. AGE: Years 49 | Months 5 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual Occupation TRUCKER.
11. Industry or business Hampden Transfer & Storage Co.

FATHER
12. Name LAWRENCE DERRY
13. Birthplace W. VA.

MOTHER
14. Maiden Name JULIA GROVE.
15. Birthplace W. VA.

16 (a) Informant Roy C Derry.
(b) Address 3619 FALLS Rd, BALT

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Falls Road

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 9 1948, at 10[illegible] AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 26 1948 to OCT 9 1948, and that I last saw him alive on OCT 9 1948.

Immediate cause of death: CORONARY THROMBOSIS & MYOCARDIAL INFARCTION — Duration 14d.
Due to ARTERIOSCLEROSIS
Due to
Other Conditions MURAL THROMBOSIS, OLD MYOCARDIAL INFARCTION (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: SAME AS ABOVE.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Brown M.D.
Address [illegible] Mem. Hosp. Date signed 10-9-48 M. D.

VS 150

667556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c ✓ Registered No. 667556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bertram S. Rice (Bertram S. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widower

6 (b) Name of ~~husband or~~ wife Cecelia M. Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1884

8. AGE: Years	Months	Days	If less than one day
63	10	20	hr. min.

9. Birthplace Colorado (Town, county, and state)
10. Usual Occupation Prop. Dress Shop
11. Industry or business

FATHER
12. Name Solomon Rice,
13. Birthplace Germany

MOTHER
14. Maiden name Hannah Nordlinger,
15. Birthplace Germany.

16 (a) Informant Mrs Bertram L. Rice
(b) Address 3907 Fordleigh Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom Cem
Location Balto. Md.

18 (a) Funeral director Abrid Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral for Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 – 10 – 1948 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9- 1948 to 10-10- 1948, and that I last saw h~~im~~ alive on 10-10- 1948.

Immediate cause of death: Pulmonary edema — Duration

Due to Cardiac decompensation

Due to Senile myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hospital Date signed 10-10-48

VS 150

G67557 ✓ G67557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LENA GOLANER ROSENSTEIN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis Rosenstein.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1872.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	6			

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Simon Golaner,
13. Birthplace Poland.

MOTHER
14. Maiden Name Anna Furstenberg,
15. Birthplace Poland.

16 (a) Informant Mr. Albert Rosenstein,
(b) Address 3711 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.11.48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Burial Association of Baltimore
(b) Address 1902 Eutaw Place.

19 (a) OCT 11 1948 (Date rec'd by registrar) Hunter-Robertson Williamson

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 10th. 1948 at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1948 to Oct 10 1948. and that I last saw h[illegible] alive on Oct 5 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other Conditions Coronary artery disease: Heart Attack. (Include pregnancy within 3 months of death)	1 mo.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Ganter M. D.
Address 3003 Garrison Blvd. Date signed 10-11-48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PAINT, WITH NON-FADING INK.

67558

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 67558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N Milton ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N Milton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Kelso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John L Kelso
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 -

8. AGE: Years 60 | Months - | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Leo Smith
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Mc K
15. Birthplace Balto

16 (a) Informant Mrs J Kelso
(b) Address 503 N Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location City

18 (a) Funeral director Leavitt Funeral Home
(b) Address 200 E Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1948, at 11 15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-6 1948 to 10-9 1948, and that I last saw h e alive on 10-9 1948.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Graber M. D.
Address Sinai Hosp Date signed 10-9-48

6675:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6675:59

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.H.
(b) Street address
(c) Hospital or institution: 1101 N. Luzerne Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A. Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct ? 1867

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Novak
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Kadan
15. Birthplace Austria

16 (a) Informant Lena Novak
(b) Address 1101 N Luzerne Ave

17 (a) Burial (b) Date thereof Oct 12th 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2108 Orleans St

19 OCT 11 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1945 at 1:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to h.c.c. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Hyp. Cardiopathy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature C. J. Schmidt M.D.
Medical Examiner.
Date signed 10/9/45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The accuracy of information should be carefully supplied. The

667560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Nies 95c

Registered No. 667560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Orleans St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nies

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Helen Nies
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 - 1874

8. AGE: Years	Months	Days	If less than one day
64	8	15	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation
11. Industry or business Upholstery

FATHER 12. Name John R Nies
13. Birthplace Balto

MOTHER 14. Maiden Name Matilda Lohn
15. Birthplace Balto

16 (a) Informant Helen Nies
(b) Address 2218 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 1800 E Orleans St

19 (a) (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10- 1948 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10- 1948 to 10-10- 1948, and that I last saw him alive on 10-10- 1948.

Immediate cause of death Pulmonary edema — Duration

Due to Cardiac decompensation

Due to Acute myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: to obtain

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Sinai Hospital M. D.
Date signed 10-10-48

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67561

476918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G67561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town St. Petersburg, (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 James, Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Vincze

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-77

8. AGE: Years	Months	Days	If less than one day
70	10	22	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER — 12. Name	Steve Vincze
FATHER — 13. Birthplace	Hungary
MOTHER — 14. Maiden Name	Susan Toth
MOTHER — 15. Birthplace	Hungary

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 12 (month) (day) (year)
(c) Cemetery or crematory St Petersburg Florida
Location

18 (a) Funeral director Ullrich Funeral Director
(b) Address 2005 Arlington Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948 to 10-10 1948 and that I last saw h in alive on 10-10- 1948.

Immediate cause of death Carcinoma of stomach with metastasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct 1948
Major findings of operation Ca of stomach with metastasis
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Henry T. Lehman, M.D.
Address JHH
Date signed 10/11/48

X

WHITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Sawyer

667562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Johanna A. Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 30, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	10	hr. min.

9. Birthplace Chicago, Illinois
(Town, county, and state)
10. Usual Occupation Analyst Kopper Corp.
11. Industry or business

FATHER
12. Name Gustav Louis Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Carolina Albravid
15. Birthplace Wisconsin

16 (a) Informant Mr. Wm. H. Beck, Jr.
(b) Address 4502 Mainfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1947 to Oct 10 1948 and that I last saw h/m alive on Oct 9 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	7 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dunnigan M.D.
Address 4808 Harford Rd. Date signed 10/11/48

VS 150

Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

G67563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157B

Registered No. G67563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2525 Kentworth Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Metzger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 9, 1948

8. AGE: Years | Months | Days | If less than one day: 22 hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Mirvin Henry Metzger
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mildred Helena Meyers
15 Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. M. H. Metzger
(b) Address: 2525 Kentworth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: L. J. Luck
(b) Address: 5305 Harford Rd

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8/ 1948 to 10/9/ 1948 and that I last saw her alive on 10/8/ 1948.

Immediate cause of death: Respiratory failure — Duration: 1 hr.

Due to: Prematurity

Due to: Cervical Agenesis
Pelvic kidney bilateral
Solitary Agenesis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature: James S. Hearne, M.D.
Address: St. Josephs Date signed 10-9-48

VS 150

Direct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467564 — 46E — Registered No. 467564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cylburn & Raymond St.
(c) Hospital or institution:
West Balt Jewish Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore 14 Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7802 Clarkswood Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Riley A. Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Emma Miller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 20th 1864
8. AGE: Years 84 | Months 0 | Days 19 | If less than one day 11 hr. 30 min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired Grocerymans
11. Industry or business

FATHER
12. Name Don Carlos Miller
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Emma Miller
(b) Address 7802 Clarkswood Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.
19 (a) OCT 11 1948 (Date rec'd by registrar) Penitentiary Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1948, to October 9th 1948, and that I last saw him alive on October 9th 1948.

	Duration
Immediate cause of death Myocardial failure	
Due to Arteriosclerotic Cardio-vascular Heart Disease	
Due to	
Other Conditions Prostatic Obstruction	

(Include pregnancy within 3 months of death)
Date of operation 9/24/48; 10/4/48
Major findings of operation: Large & Small bowel obstruction.
of autopsy: Mal. Md., Ca of colon, peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howe Linn Grant M. D.
Address Date signed

VS 150

PRINT WITH PENCIL, WITH ONE PADDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669565 ✓ 669565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6727 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 6727 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gompf

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lillie J. Gompf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1859

8. AGE: Years	Months	Days	If less than one day
89	11	20	hr. min.

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation Retired gardener
11. Industry or business

FATHER
12. Name Peter Gompf
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Lillie J. Gompf
(b) Address 6727 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co.

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown, Md.

19 Oct 13 1948 (b) [illegible] (Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948 at 4- P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23, 1945, to Oct. 11 1948, and that I last saw him alive on Oct. 11, 1948.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Chronic Myocarditis	?
Due to Arterio Sclerosis and Senility	?
Other Conditions Cerebral hemorrhage December 1945	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Nicas M.D.
Address Pikesville-8 Md. Date signed 10/12/48

VS 150

G 67566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G 67566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Denison Rd.
(c) Hospital or institution: 2841
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Woodbine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE PFAFF

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry V. Pfaff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 5, 1868

8. AGE: Years: 80 | Months: 6 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: -

11. Industry or business

FATHER
12. Name: John Krausz
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Weller
15. Birthplace

16 (a) Informant: Mrs. H. H. Vogel
(b) Address: 2519 Denison Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICHNER & SONS
(b) Address: Balto., Md.

OCT 13 1948 (b) (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1938 to 10-12 1948, and that I last saw h[illegible] alive on 10-12 1948.

Immediate cause of death	Duration
Arteriosclerosis	
Hypertension. Diabetes	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/13/48

Dr John A. Lotcher
67357 Eager 57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 67357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 McKeon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 McKeon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles A. Hildebrandt

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 14 1883

8. AGE: Years	Months	Days	If less than one day
65	6	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Charles H Hildebrandt
13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna C. Hampel
15 Birthplace Baltimore

16 (a) Informant Betty Jo Hildebrandt
(b) Address 426 Graystone Terrace

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt Hebron Cem
Location Winchester Va

18 (a) Funeral director Wm Cook Inc.
(b) Address 1216 S. Paca St

19 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1923 to Oct 11 1948, and that I last saw him alive on Oct 11 1948.

Immediate cause of death Cancer of Lung + metastasis to Brain — Duration Known 6/15/48
Due to
Due to
Other Conditions Myocardial Insufficiency — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno A Lotcher M. D.
Address 12 E Eager St (Balto 2) Date signed Oct 11/48

G67568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 50

Registered No. G67568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 St. Paul St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Roberta Ann Ashcom

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 15, 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	11	25		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John L. Ashcom
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Robert Ann Bean
15. Birthplace Baltimore, Md

16 (a) Informant Nellie F. Collison
(b) Address 3120 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
Washington Williamson, Md

19 (a) [redacted] (Date rec'd by registrar) Registrar

12 [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948, at 6:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948, to 10-10 1948, and that I last saw her alive on 10-10 1948

Immediate cause of death	Duration
Metastatic carcinoma of lung & dura	
Due to Generalized carcinomatosis, abdomen &	
Due to Carcinoma, left breast	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Beamon P. Brown, M.D.
Address Union Memorial Hospital Date signed 10/11/48

VS 150

667569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

667569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Annor Court.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Annor Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Ellsworth Linton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Bessie Linton

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan-25-1885

8. AGE: Years 63 Months 8 Days 16 17 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Fireman (retired)

11. Industry or business

12. Name of father James W. Linton

13. Birthplace Baltimore

14. Maiden Name of mother Elizabeth Goodman

15. Birthplace Baltimore

16 (a) Informant Mrs. Bessie Linton

(b) Address 2405 Annor Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)

(c) Cemetery Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) [illegible] (Signature if filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948 at 9 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct-11-1948, and that I last saw h[illegible] alive on October-11-48

Immediate cause of death

Cancer of the lung — Duration about 16 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Biopsy of Aug 48

Major findings of operation: Cancer of left lung, metastases in [illegible] of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M.D.

Address 2708 Hollins Ferry Rd Date signed 10/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. ~~6676675~~70

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Darley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Darley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Martha Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business Revenue Officer

FATHER 12. Name Geo Walker
13. Birthplace Baltimore

MOTHER 14. Maiden Name Rivers
15. Birthplace Balto

16 (a) Informant Mrs Mary Thomas
(b) Address 1630 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Aliceanna St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 12 1948 Huntington Station, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948, at 3 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Oct 9 1948 and that I last saw him alive on Oct 8 1948

Immediate cause of death: Cardiac Decompensation — Duration Oct 8/48
Due to
Due to
Other Conditions: Chronic Hypertension (arteriosclerosis) — a number of years
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norma B. Green M. D.
Address 3009 Greenmount Ave Date signed 10/11/48
Baltimore 14 Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

667572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Overview Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Overview Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mondschein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace Hungary

MOTHER
14. Maiden Name not known
15. Birthplace Hungary

16 (a) Informant Eugene Mondschein
(b) Address 3708 Overview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Kewly Inc
(b) Address 2166 Eutaw Place
(c) Filed OCT 12 1948 Turntator Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1948, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1948 to 10/11 1948.
and that I last saw h/M alive on 10/12 1948.

Immediate cause of death: acute enterocolitis — Duration: 3 mos
Due to
Due to
Other Conditions Gen. Arteriosclerosis, Senility — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Feldman M. D.
Address 87 St Paul St Date signed 10/ 6

CAUTION: This certificate, when completed, will be filed by the registrar. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 32422

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lunar 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Lunar Aged Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Strauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Bernard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day hr.	min.
85				

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Morris Steuer
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary
15. Birthplace Hungary

16 (a) Informant George Foith
(b) Address 3310 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

OCT 12 1948 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1948, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948, to 10-11 1948, and that I last saw h e alive on 10-8 1948.

23. Immediate cause of death	Duration
Severe Anemia	
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Fisher M. D.
Address Lunar Hosp Date signed 10-14-48

VS 150

G67573 X ✓ G67573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. County
(c) City or town: Hickory (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME M. WILLIAM SMITH

3 (b) If veteran, name war World War 2

3 (c) Social Security Account No 244-34-1880

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced (Single)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-1921

8. AGE: Years	Months	Days	If less than one day
27 (48)	0	27	hr. min.

9. Birthplace (Gaston) Burke Co., N.C. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Motor Freight

FATHER
12. Name Jerry M. Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Dennis (Vinna) Grace Shoe
15. Birthplace North Carolina

16 (a) Informant John O. Mitchell
(b) Address 1900 Eutaw Place

17 (a) 10/11/48 (b) Date thereof 10/13/48 (month) (day) (year)
(c) Burial, cremation or removal Oak Grove Cem.
(d) Cemetery or crematory Gastonia N.C.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw pl. Baltimore, Md.

19 [redacted] (Accepted by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 12 25 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull & intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the followin

(a) Date of injury 10-10-48 at 11:55 P. M.
(b) Where did injury occur? Washington Blvd. at Patapsco River Bend Balto. County, Md.
(c) Did injury occur at home, on farm, in factory, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature Emil L. Kyle M.D. Medical Examiner.
Date signed 10-11-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6675

6675 6675 9 E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Bancroft Road
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Bancroft Road. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3. (a) FULL NAME NATHAN ADLER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rachel Adler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 28, 1878.

8. AGE: Years 70 Months 6 Days 13/14 If less than one day: hr. min.

9. Birthplace: Germany. (Town, county, and state)

10. Usual Occupation: Retired Executive
11. Industry or business

FATHER
12. Name: Selig Adler,
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Rifka Selz,
15. Birthplace: Germany.

16. (a) Informant: Mr. Sidney Adler,
(b) Address: New York.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48. (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew
Location: Balto. Md.

18. (a) Funeral director: Harris Levine & Son
(b) Address: 1902 Eutaw Place.

19. Date received by registrar: Oct 12 1948 Clayton Hollander, Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: Oct. 11th. 1948 at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 11, 1948, and that I last saw h[illegible] alive on Oct 11, 1948.

Immediate cause of death: Myocardial Insufficiency — Duration
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: Nil
Major findings of operation: Nil
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: Sidney I. Jay
Address 2322 Eutaw Pl. Date signed 10/12/48 (M D Y)

VS 150

6675?5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6675?5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Colborne Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE T. DOCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0264

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary E. Dock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1889

8. AGE: Years	Months	Days	If less than one day
59	9	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation machinist
11. Industry or business Crown Cork and Seal

FATHER
12. Name George ". Dock
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Mary C. Casgro
15. Birthplace Chambersburg, Pa.

16 (a) Informant Mary E. Dock
(b) Address 3716 Colborne Rd.

17 (a) Burial (b) Date thereof 10/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Boulevard

18 (a) Funeral director Charles P. Towell
(b) Address 2427 Edmondson Ave.

OCT 12 1948 Baltimore, Md.
(Date rec'd by registrar) Registrar

V3 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1948, at 9:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or secondary ☐ cause of death, fill in the following:
(a) Date of injury at
(b) Where did injury occur?
(c) Did injury occur in home ☐ factory ☐ street ☐ public place? (Specify)
(d) Means of injury

23. Signature
Date signed

667576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

667576
Registered No.

Physicians: please write the causes of death clearly and legibly. Spaces are especially important. Omission of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Chester street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE STOLL

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: Michael Stoll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870

8. AGE: Years 78 | Months 7 | Days 27 25 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fred Kahler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant Mrs Walter F. Snellings
(b) Address 1815 N. Chester Street - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory Moreland memorial
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
(c) OCT 12 (Date rec'd by registrar) (d) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 19 48, 4.25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 19 47 to Oct 9 19 48.
and that I last saw her alive on Oct 9 19 48

Immediate cause of death: Acute Cardiac Failure — Duration: 18 hrs

Due to Chr. myocarditis

Due to Diabetes Mellitus

Diabetic Carbuncles.

Other Conditions Diabetic cataracts.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Harding M. D.
Address 3805 Belair Rd Date signed Oct 11/48

VS 150

G67577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G67577 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5000 Denmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Abell

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1860

8. AGE: Years 87 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace St. Marys Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business R. N.

FATHER
12. Name George Abell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Benson
15. Birthplace Md.

16 (a) Informant John W. Abell
(b) Address 5000 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Arlington, Va.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave. - 17

19 (a) OCT 13 1948 (Date received by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 1948.
and that I last saw her alive on Aug 15 1948.

Immediate cause of death: Cerebral Thrombosis

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Gaines M. D.
Address 1211 Cathedral St Date signed Oct 14 1948

V S 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G667578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Haskin Court (If rural give location)
(e) Citizen of foreign country? Husband No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EPHRIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1894

8. AGE: Years	Months	Days	If less than one day
54	8	4	hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name George Ephrian
13. Birthplace Unknown

MOTHER
14. Maiden Name Ida Haines
15. Birthplace Alabama

16 (a) Informant Mrs. Eliza Ephrian
(b) Address Berkley, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory Wildwood Cem.
Location West Virginia

18 (a) Funeral director MRS. FRANCES A. HEMSLEY
(b) Address 578 W. Biddle Street

OCT 12 1948
(Date rec'd by registrar) Remington Hillsborough

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart.
Acute edema of lungs.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 10-11-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 667579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERTA CHEW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name John Gordy
13. Birthplace Md

MOTHER — 14. Maiden Name Louise Brown
15. Birthplace Md

16 (a) Informant Mr. John Gordy
(b) Address 15-3 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mr. Frances A. Hemsley
(b) Address 57 E. O. Biddle St.

19 (a) [redacted] (b)
(Date received by Registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948, at 8:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1948 to Oct 4 1948, and that I last saw her alive on Oct. 4, 1948.

	Duration
Immediate cause of death: Hypertensive Cardio-Renal Disease	2 months
Due to: Hypertensive Cardio-Vascular Disease	6 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer W. Harris Jr. M. D.

Address 1824 W. Franklin St Date signed 10-9-48

PRINT WITH PLAIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667580 80

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Winters Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDITH M. BROWN CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1917

8. AGE: Years	Months	Days	If less than one day
31	4	8	hr. min.

9. Birthplace Catonsville, Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Dumas Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Hall
15. Birthplace Maryland

16 (a) Informant Mrs. Martha Brown
(b) Address 18 Winters Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 OCT 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 8.15 p.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Stab wounds of chest and abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-48 at approx. 7.50 p. M.
(b) Where did injury occur? 18 Winters Lane
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp Instrument

23. Signature [signature] M.D. (Medical Examiner)
Date signed October 11, 1948

VS 151

Please write as especially important. Physicians: please write the causes of death clearly and legibly.

967581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164E

967581 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. #506 St. James Apts., 530 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULU MAY HAGNER
3 (b) If veteran, name war
3 (c) Social Security Account No. 22749

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Richard A. Hagner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 31, 1878
8. AGE: Years 70 | Months 8 | Days 11 | If less than one day hr. min.
9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Walter Foster
13. Birthplace England
MOTHER 14. Maiden Name Emma Collins
15. Birthplace Va.
16 (a) Informant: Mr. Donald F. Hagner
(b) Address Hopkins Apts., St. Paul & 31St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.
18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1948, at 8:45AM
21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH: Fracture & Skull
Fractured cervical Vertebral
Compound fracture Radius & Ulna (right)
Due to
Mental depression
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 11/48 8:30 AM.
(b) Where did injury occur? 5th Floor, St. James Apts.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Jumped from fire escape
23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10/11/48

VS 151

G67582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 757 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 757 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE DURHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Logan Durham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1874

8. AGE: Years	Months	Days	If less than one day
74	8	1	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Southwood
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Della Durham
(b) Address 757 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Oct 9, 1948.
and that I last saw her alive on Oct 9, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Day
Due to: Hypertension — Years
Due to:
Other Conditions: Cardiac Insufficiency
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St. Date signed 10/12/48

VS 159

Please write carefully. Physicians: please write the causes of death clearly and legibly.

G67583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G67583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53
(e) Length of stay in Baltimore (yrs., mos., or days) 65yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 Beaumont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country NO

3 (a) FULL NAME Mrs Carrie E. Lober.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single Widowed

6 (b) Name of husband or wife: NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1882

8. AGE: Years 65 | Months 11 | Days 10 | If less than one day: hr. 9 min. 21

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Conrad Lober
13 Birthplace Maryland

MOTHER
14. Maiden Name Caroline Wagner
15 Birthplace Maryland

16 (a) Informant: Mrs Carrie Sendrek
(b) Address 2867 Edmondson Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 EDMONDSON AVE.

19 (a) Date received (Registrar) OCT 12 1948 (b) Registrar Winston Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1948 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Oct 10 1948, and that I last saw h c alive on Oct 1 1948.

Immediate cause of death: General Peritonitis.
Duration: 41 days

Due to Diverticulum of Stomach w duodenum.
Due to ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation August 2nd + 29th 1948

Major findings of operation: Diverticulum of [illegible] General Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P Grove M. D.
Address Union Memorial Hospital Date signed 10-10-48

X

G67584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67584 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md. 20
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Wilson Point Rd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilhelmina Neunsinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1882

8. AGE: Years: 66 | Months: 2 | Days: 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Postal Service

FATHER
12. Name John T. Owens
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Brown
15. Birthplace Md.

16 (a) Informant Mrs. Wilhelmina Owens
(b) Address 1706 Wilson Pt. Rd., Ba. Co. 20 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Maryland

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

OCT 13 1948 (Date rec'd by registrar)

(By) Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1948 at 1 20 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-27 1948 to 10-9 1948 and that I last saw him alive on 10-9 1948

Immediate cause of death
Lobar Pneumonia — (a) Duration 11 days

Due to Anterior Myocardial Infarction due to Coronary Thrombosis — 14 days

Due to Arteriosclerotic Heart Disease — 6 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Newell M. D.
Address 1213 Light St. Date signed 10-9-48

VS 152

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G667585

BALTIMORE CITY HEALTH DEPARTMENT ✓ G667585 85
Registered No.

CERTIFICATE OF DEATH 74a

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 Irving st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patsy Ann Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1933

8. AGE: Years	Months	Days	If less than one day
15	3	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School-girl

11. Industry or business

FATHER
12. Name Robert M. Bennett
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Bertha V. Krauss
15. Birthplace Baltimore Md

16 (a) Informant Robert M. Bennett
(b) Address 146 Irving st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Laurel Md

18 (a) Funeral director Mrs. Mrs. Otho W. Linthicum
(b) Address 5311 Edmondson Ave

19 (a) Oct 12 1948 Wallington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948 at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948, to 10-10 1948, and that I last saw her alive on 10-10 1948.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Chronic Myelogenous Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gabel M. D.
Address Sinai Hosp Date signed 10-10-48

VS 150

X

G67586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G67586 Registered No. 86

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 Guilford Terrace
(c) Hospital or institution none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Guilford Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Anne Robertson Foster

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Edward E. Foster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 14, 1870

8. AGE: Years	Months	Days	If less than one day
78	7	27	hr. min.

9. Birthplace Chase City, Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Reps O. Osbourne
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Wallace Robertson
15. Birthplace Va.

16 (a) Informant Mrs. Angeline F. Williams
(b) Address RFD #2, Annapolis, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location North & Greenmount Aves., Balto.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 OCT 12 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/6 1948 to 10/11 1948, and that I last saw h[illegible] alive on 10/4 1948.

Immediate cause of death Uremia — Duration 2 days

Due to Generalized arteriosclerosis. — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature George W. Mugler Jr. M.D.
Address 1114 St. Paul St. Date signed 10/12/48

VS 150

Instructions: Physicians: please write the causes of death clearly and legibly. The age is especially important. Information should be carefully supplied. (The

G67587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67587 87 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2453 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2453 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marian Bell Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife F. Howard Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 26-1890

8. AGE: Years	Months	Days	If less than one day
58	5	15	hr. / min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name John J. Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Jean S Speir
15 Birthplace Maryland

16 (a) Informant F. Howard Smith
(b) Address 2453 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John A. Mitchell & Sons, Inc
(b) Address 1900 Eutaw Pl.

1948 OCT 12 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 11 1948, and that I last saw her alive on Oct 10 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Hypertensive Cardio Vascular disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Smith M. D.
Address 3429 Chestnut Ave. Date signed Oct 16. 48

X

HLH - 2 G67588 BALTIMORE CITY HEALTH DEPARTMENT X G67588 Registered No. 88

CERTIFICATE OF DEATH 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Clark (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Guthrie Wetherington
3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-15-47

8. AGE: Years | Months: 10 | Days: 26 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Luke Wetherington
13. Birthplace N.C.

MOTHER 14. Maiden Name Mable Guthrie
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 (month) 12 (day) 48 (year)
(c) Cemetery or crematory Smaw-Harris
Location New Barn, North Carolina

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31, Md.

19 (a) Filed (b) Registrar

OCT 12 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948, to 10-11 1948, and that I last saw him alive on 10-11 1948.

Immediate cause of death	Duration
a Nefrenia	
Due to Congenital Heart disease	
Due to	
Other Conditions 0	

(Include pregnancy within 3 months of death)

Date of operation 10/11/48
Major findings of operation: Pul Atresia: dextroposition of aorta
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Albert Olsen
Address Johns Hopkins Hospital Baltimore
Date signed 10-12-48

VS 150

The ... should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G67589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67589

Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution:
West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs 36 min
(e) Length of stay in Baltimore (yrs., mos., or days) Never

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Oak Lane 8
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace West Balto Gen. Hosp.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Edward Cunningham
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mildred Leona Wade
15 Birthplace Glen Bernie Md

16 (a) Informant: Mrs. Mildred Cunningham
(b) Address 100 Oak Lane Glen Bernie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Glen Bernie Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

(Date rec'd by registrar) Washington Millington, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1948 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1948 to 10/11 1948, and that I last saw her alive on 10/10 1948.

Immediate cause of death	Duration
Congenital Heart Lesion	
Due to Causes unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto Gen. Hosp Date signed 10/12

VS 150

G67590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67590 Registered No.

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 yr 5 mo. 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days): as "d"

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ill. (b) County:
(c) City or town: Chicago (If outside city or town limits, write RURAL and give town)
(d) Street No.: 9229 Commercial Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: HASSETT, Thomas Joseph

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	x

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	13	hr. min.

9. Birthplace: Chicago, Ill (Town, county, and state)

10. Usual Occupation: Asst. steward

11. Industry or business:

FATHER
12. Name: Patrick Hassett
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Hair
15. Birthplace: Ireland

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-12-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location: Linwood Ave

18 (a) Funeral director: Jas B Johnston Sons
(b) Address: 403-6-26 E 25th St

19 (a) (b) (Signature of registrar) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1948, at 5:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 22, 1947, to Oct. 9, 1948 and that I last saw him alive on Oct. 9, 1948.

Immediate cause of death	Duration
1. Carcinoma of left alveolar ridge with metastases	22 months
Due to 2. Fracture, left femur	9 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-29-48 at 10.30 AM
(c) Where did injury occur? U. S. Marine Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury: Fainted and fell to floor

23. Signature: John L. Wilson M. D.
Address: Clinical Director Date signed 10-9-48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G67591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Joppa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 2-21-85

8. AGE: Years 63 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Frank Johnson
13. Birthplace: Md

MOTHER
14. Maiden Name: Elizabeth Boozle
15. Birthplace: Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct-12-1948 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Rest.
Location: Towson Balto Co Md.

18 (a) Funeral director: Bayard Ingram & W A Wright
(b) Address: 721 Eighteenth St

19 (a) (Signature of registrar) Huntington Williams, Registrar
(b) OCT 12

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-1948 to 10-9-1948 and that I last saw her alive on 10-9-1948.

Immediate cause of death: Myocardial infarction — Duration

Due to Coronary thrombosis

Due to Syphilitic aortitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Infarction, myocardium, coronary thrombosis, coronary atherosclerosis, syphilitic aortitis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town), (County), (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature John Collins Harvey M D
Address Johns Hopkins Hospital Date signed Oct 12-48

Age is especially important. Physicians: please write the causes of death clearly and legibly.

G67592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid Hill Ave
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Greene St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Woods

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	W.

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov - 1887

8. AGE: Years	Months	Days	If less than one day
60	11		hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Harper
13. Birthplace Md.

MOTHER 14. Maiden Name Matilda
15. Birthplace Md.

16 (a) Informant Charles Woods
(b) Address 1804 Lanvetta Ave

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G. A. Co.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) 10-9-1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7- 1948, to 10-8-1948, and that I last saw her alive on 10-8- 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Brady, M. D.
Address Provident Hosp Date signed 10-9-48

VS 150

G67593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52R

G67593 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st Street
(c) Hospital or institution: U. S. Marine Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: -
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 101 W. Monument Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Capt IVERSON, GEORGE DUDLEY - Jr

3 (b) If veteran, name war: VA 1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	white	m

6 (b) Name of husband or wife: Alice Iverson (Mrs.)
6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	13	14 hr. ... min.

9. Birthplace: Baltimore — Maryland (Town, county, and state)
10. Usual Occupation: none (Retired)
11. Industry or business: U. S. Army

FATHER
12. Name: George D. Iverson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Alice Keeble
15. Birthplace: Virginia

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a): Cremation (Burial, cremation, or removal) (b) Date thereof: 10 - 13 - 1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: [illegible]

19 (a) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1948, at 9:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10, 1948 to Oct. 11, 1948, and that I last saw him alive on Oct. 11, 1948.

Immediate cause of death	Duration
1-Arteriosclerotic heart disease	
with coronary occlusion, partial	4 days
Due to:	
Due to:	
Other Conditions: 2-Carcinoma, urinary bladder	6 months

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
Address: John L. Wilson, Clinical Director
Date signed: 10-11-48 M. D.

V S 150

93D

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G67594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G67594
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 N. Bentalou St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILY WADKIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Harry Wadkin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Jan. 16, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	24	hr. min.

9. Birthplace Sussex, England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Holloway
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Nash
15 Birthplace England

16 (a) Informant Mrs. Gertrude M. Drexel, daughter
(b) Address 832 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Addr Balto., Md.

(Date rec'd by registrar) 12 Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 7:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1939 to Oct 10 1948 and that I last saw h alive on Oct 8 1948

Immediate cause of death Arteriosclerotic Cerebro-Thrombosis
Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Schechter M. D.
Address 202 Edmondson Ave Date signed 10/11/48

L. J. Schechter

VS 150

BC-48-21520 G662595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. G662595

The entries on this certificate should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. 11 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country /

3 (a) FULL NAME Baby Linda Ann Liptrap

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1948

8. AGE: Years	Months	Days	If less than one day
0	0	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Leonard Liptrap
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Zittle
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Leonard Zittle
(b) Address 1304 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1948 at 3 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1948 to Oct. 11 1948, and that I last saw h alive on Oct. 11 1948.

Immediate cause of death	Duration
Immediate cause of death: Exanition, dehydration	
Due to: Diarrhea	
Due to: Cause undetermined	
Other Conditions: Bilateral pneumonia (Include pregnancy within 3 months of death)	

Date of operation none

Major findings of operation:

of autopsy: Bilateral pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.

Address W 34 H Date signed 10/14/48

X

G67596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52

G67596 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The accuracy of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MAGGIE ELLSWORTH ECCLESTON

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1864

8. AGE: Years 84 | Months 1 | Days 28 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Charles E. Eccleston
13. Birthplace Baltimore, Md.

MOTHER: 14. Maiden Name Margarita Grace
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. A. Mihn
(b) Address 2302 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Registrar) [illegible] Registrar

Oct 12 1948

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948, 10:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 1 1948 to Oct. 10 1948 and that I last saw her alive on Oct. 10 1948

Immediate cause of death: Cancer Fall
Due to Coma, due to
Due to Hemorrhage of the brain
Due to
Other Conditions

Duration: 8 yrs. 9 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman R. Mantz M. D.
Address 2601 Maryland Ave Date signed Oct 11 48

Herman R. Mantz

G67597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

36

Registered No. G67597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 313 W. 28th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Wilkins (Jeanette Farrell Wilkins)
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948, at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 10 1948 and that I last saw her alive on Oct 10 1948.

Immediate cause of death Poliomyelitis, Paralytic, Bulbospinal — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 27, 1929

8. AGE: Years	Months	Days	If less than one day
19	7	13	hr. min.

9. Birthplace Baltimore, MD (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Edward Farrell
13. Birthplace ?, Virginia

MOTHER
14. Maiden Name Helen? Edmonds
15. Birthplace Va

16 (a) Informant Deceased Patient
(b) Address

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Oct 12-48 (month) (day) (year)
(c) Cemetery or crematory Lawrence Cemetery
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

OCT 12 1948 (Date rec'd by Registrar) (b) for Williams, M. Registrar

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gayle B. Arnold M. D.
Address Sydenham Hosp. Date signed 10-10-48

V S 190

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any errors or omissions should be carefully supplied. The

Dr. Morris Shamer
3300 W. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82a

Registered No. 662598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 Holder Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Holder Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Homlet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: ~~Chinese~~ white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Leola Homlet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1882

8. AGE: Years 65 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace San Francisco, Calif. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fong Hom
13. Birthplace China

MOTHER
14. Maiden Name Soo
15. Birthplace China

16 (a) Informant Mrs. Leola Homlet
(b) Address 5109 Holder Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (Date received by Registrar) OCT 12 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10th 1948 at 2.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4, 1948 to Oct. 10, 1948 and that I last saw him alive on Oct. 9, 1948

Immediate cause of death: Cerebral thrombosis — Duration: 7 days
Due to: Hypertension — ?
Due to:
Other Conditions: Cerebral hemorrhage — 2 mo
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Maurice L. Shamer M.D.
Address 3300 W. North Ave. Date signed 10/11/48

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The accuracy is especially important.

G67599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67599 Registered No.

Please write clearly with pen or pencil. Use no abbreviations. If information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Latrobe Apts
(b) Street address — Charles & Read Sts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs?

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County —
(c) City or town — Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. — Latrobe Apts. Charles & Read Sts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Moale Nicholas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 21 1872
8. AGE: Years 76 | Months 3 | Days 8 | If less than one day hr. min.
9. Birthplace Balto Co Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wilson Cary Nicholas
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Augusta Moale
15. Birthplace Balto. City

16 (a) Informant C. M. Wedbee
(b) Address 1515 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1948 (month) (day) (year)
(c) Cemetery or crematory St Charles
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address Mt 4965 York Rd

19 (a) Oct 12 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948, at 4.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 11 1948 and that I last saw him alive on Oct 10 1948

Immediate cause of death: Coronary Thrombosis — Duration 4 Days
Due to: Arteriosclerosis, generalized
Due to:
Other Conditions: Paralytic Ileus cause undetermined
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Pearce M. D.
Address 2105 N Charles St Date signed Oct 11 1948

VS 150

G67600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67600
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 S. Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA GRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 20, 1872

8. AGE: Years 76 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bailey
13. Birthplace unknown

MOTHER
14. Maiden Name
15 Birthplace unknown

16 (a) Informant Mrs. Elizabeth Henderson
(b) Address 50 Buttonwood Rd. Staten Island

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 OCT 13 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 48 to October 12 19 48, and that I last saw her alive on October 11 19 48.

Immediate cause of death: Bronchopneumonia — Duration: 3 days
Due to: senility
Due to:
Other Conditions: Arteriosclerosis, Hypertension, Chronic Myocarditis
Left complete hemiplegia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 10/12/48

VS 189

107

Especially important: Physicians: please write the causes of death clearly and legibly. The [illegible] carefully applied. The

667601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

667601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. 24th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE W. WAGNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) ~~Single~~ married, ~~widowed, divorced~~
Male	White	Married

6 (b) Name of husband or wife Peggy Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1895

8. AGE: Years	Months	Days	If less than one day
52	9	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Lewis Brothers

FATHER
12. Name Dr. Frank E. Wagner
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Alice C. Ward
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Peggy Wagner
(b) Address 311 E. 24th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Filed by Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 5:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull with intracranial hemorrhage

Due to

Other Conditions Multiple fractures of ribs and clavicle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1617
(a) Date of injury 10-9-48 at 12:30 P. M.
(b) Where did injury occur? 3192 Brighton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Roof of home While at work? Yes
(d) Means of injury Fell from roof while painting

23. Signature Carl L. Wagner M.D.
Medical Examiner.
Date signed 10-12-48

67602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67602

121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Gregory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baid Linda Bergman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT. 7, 1946

8. AGE: Years	Months	Days	If less than one day hr.	min.
2	1	5		

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name GILBERT D. BERGMAN

13. Birthplace MISS.

MOTHER 14. Maiden Name EDNA A. McCULLEY

15. Birthplace MARYLAND

16 (a) Informant GILBERT D. BERGMAN

(b) Address 1104 GREGORY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory WESTERN

Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK, INC

(b) Address 1217 ST. PAUL ST.

19 OCT 13 1948 (Date rec'd by Registrar) (By) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948, at 1 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct. 12 1948, and that I last saw h er alive on Oct. 12, 1948

Immediate cause of death: Generalized peritonitis following gangrenous appendicitis with perforation — Duration: 6 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 12, 1948

Major findings of operation: Ruptured gangrenous appendix and generalized peritonitis

Autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Langer, M.D.

Address Bon Secours Hospital Date signed 10/12/48

VS 150

67603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G67603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution Good Samaritan Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N Gusquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eula Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18-1897

8. AGE: Years 50 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Birmingham Ala (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Jesse Robinson
13. Birthplace Ala

MOTHER 14. Maiden Name Rena Robinson
15. Birthplace Ala

16 (a) Informant Dr Mc Elroy
(b) Address 1402 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Payne Sanders
(b) Address 1412 E Preston St

19 OCT 13 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct 9 1948 and that I last saw her alive on Oct 9 1948

	Duration
Immediate cause of death Myocarditis	unknown
Due to Cancer Rectum	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen E Forbes
Address 501 Edmondson Date signed 10/13/48

V S 150

Instructions: Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. Age is especially important.

Medical Examiners Case

67604 JL - 123056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Melville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7, 1860

8. AGE: Years 88 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sam Clark

13. Birthplace Md.

MOTHER 14. Maiden Name Ann

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Gustin E. Donovan

(b) Address 3638 Roland Ave

19 OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

CERTIFICATION APPROVED BY

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948 at 3PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 17 1948 to Oct. 11 1948. and that I last saw her alive on Oct. 11 1948.

Immediate cause of death: Pulmonary Edema — Duration 4 hrs

Due to arterio Sclerotic Heart disease. years

Due to

Other Conditions Fractured neck of R Femur. — 27 days

(Include pregnancy within 3 months of death)

Date of operation 9-26-48

Major findings of operation: Fractured femur.

9-29-48

of autopsy: Pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 9-15-48 at M

(c) Where did injury occur? Baltimore (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury fell. Slipped and fell to floor

23. Signature [illegible] M. D.

Address 4940 Eastern Ave Date signed 10-17-48

To be approved by Medical Examiner

VS 150

Please write the causes of death clearly and legibly.

G67605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G67605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5920 Bell Grove Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE MAE UTLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1901

8. AGE: Years 47 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Sardis, Georgia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ben Coglin
13. Birthplace Georgia

MOTHER
14. Maiden Name Sallie Ellison
15. Birthplace Georgia

16 (a) Informant Bennie Coglin
(b) Address 1726 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Balto Co

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

OCT 13 1948 (Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 9.50 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Compound Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at approx. 7.55 p. M.
(b) Where did injury occur? Hoffman St. & Bell Grove Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Struck by auto

23. Signature Emil K. Rogers M.D.
Medical Examiner
Date signed October 12, 1948

667606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

667606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Baker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNAH SPENCER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age 1891 years

7. Birth date of deceased (mo., day, yr) July 8, (1871)

8. AGE: Years	Months	Days	If less than one day
57	3	3	hr. min.

9. Birthplace Pikesville, Maryland. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George Houston
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Laura Sullivan
15. Birthplace Maryland.

16 (a) Informant Mrs. Anita Diggs
(b) Address 834 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 OCT 13 1948 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11- 1948, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1948 to 10-11-1948 and that I last saw h[illegible] alive on 10-11- 1948.

Immediate cause of death Gastric Carcinoma — Duration
Due to Chron Gastritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Don't Know
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Boykin M.D.
Address 1133 Monroe Date signed 10/12/48

VS 153

G67607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SILAS BERRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Eliza Berry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	24	hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mattie Brown
(b) Address 521 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimote, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 1948, at 2 45 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/12 1948 to 10/10 1948, and that I last saw h alive on 10/10 1948.

Immediate cause of death Cardio Vascular Renal Disease
Due to arteriosclerosis

Duration: 2 yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Jackson M. D.
Address 600 N. Arlington Ave. Date signed 10-12-48

VS 193

67608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66[illegible]13

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM THOMAS CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 30, 1876

8. AGE: Years: 72 | Months: 4 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Lynchburg, Va.
(Town, county, and state)

10. Usual Occupation: Caterer

11. Industry or business

FATHER
12. Name: William H. Carter
13. Birthplace: Lynchburg, Va.

MOTHER
14. Maiden Name: Courtney Carter
15. Birthplace: Lynchburg, Va.

16 (a) Informant: Mrs. Florence Hughes Carter
(b) Address: 1417 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/'48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial Pk.
Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948 to 10-12 1948 and that I last saw h[illegible] alive on 10-11 1948

Immediate cause of death: Acute Cardiac Dilatation

Due to: Coronary Thrombosis Acute?

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Duration:

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2033 Eutaw Place Date signed 10/14/48 M. D.

VS 150

667609 D.C. 12-2888

2988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

667609 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Marie Blythe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/48

8. AGE: Years | Months | Days 3day | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Woman Infant
11. Industry or business

FATHER
12. Name Theodore Blythe
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret Blythe
(b) Address 828 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leo F. Kelson
(b) Address 1303 Pleasant St

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Entering Millinery Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/48, at 8:37 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1948, to 10/12 1948
and that I last saw h alive on 10/12/48

Immediate cause of death
Parchet Hemorrhage?
Prematurity
Due to
Due to Toxemia of Pregnancy
Other Conditions
(Include pregnancy within 3 months of death)

Duration 3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 10/12/48 at 5:27 P.M.
(c) Where did injury occur? Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Louis Jones M.D.
Address 1100 Druid Hill Ave Date signed 10/12/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67610

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Esther Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob Hooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 5, 1903

8. AGE: Years 45 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

FATHER
12. Name Solomon Tulgham
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jd. James
15. Birthplace Va.

16 (a) Informant Helen Hooper
(b) Address 926 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Octoba 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial.
Location

18 (a) Funeral director Wm Kater R. Williams
(b) Address 922 W. Lanvale St.

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Cuntington Williamsburg Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1948, at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1948 to 10/8 1948, and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death
Uraemia

Duration
Years
3 wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm Comer M. D.
Address 753 George St. Date signed 10/11/48

VS 150

667611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667611 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM WASHINGTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1898

8. AGE: Years	Months	Days	If less than one day
50	6		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Washington
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Annie Wells
(b) Address 949 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory W. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Katie R. Williams
(b) Address 3229 W. Lanvale St

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948 at 9:48AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner
Date signed Oct. 11, 1948

G67612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124R

G67612 Registered No.

Please write the entries or death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2633 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 E. Madison St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. RUZICKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Charvat Ruzicka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 15. 1876

8. AGE: Years 71 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation retired police

11. Industry or business

FATHER 12. Name Frank J. Ruzicka
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Anna Bolek
15 Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary Charvat Ruzicka
(b) Address 2633 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 10 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Oct 10 1948, and that I last saw him alive on Oct 10 1948

Immediate cause of death: (a) Hypostatic Pneumonia — Duration: Oct 7 48
Due to (b) Carcinoma of Liver — Duration: April 48
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bonner M. D.
Address 8014 Kenwood Ave Date signed 10/11/48

VS 150

G67613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 1a

G67613
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Erdman Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4552 Sheldon Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Dvorak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~ Frank Dvorak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 30, 1874

8. AGE: Years 74 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Vaclav Sappe
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Clara D. Kandlik - dght.
(b) Address 2708 Erdman Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location North Ave. & Oliver St.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) Date received by registrar OCT 18 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to October 12 1948 and that I last saw h alive on October 11 1948.

Immediate cause of death	Duration
Hypertension, Cardiovascular Renal Disease	1 Mo.
Due to	
Due to	
Other Conditions Uraemia	6 Days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Alex L. Sokarsky M. D.
Address 2939 McElderry Date signed 10/14/48

G67614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

✓ G67614
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Rest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Denmead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Denmead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Freede
13. Birthplace Germany

MOTHER
14. Maiden Name Walberta ?
15. Birthplace Germany

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

OCT 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1948, at 3:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948, to Oct 12 1948, and that I last saw her alive on Oct 11 1948.

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Patterson
Address 2324 Reisterstown Rd Date signed 10/12/48 (M. D.)

G67615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1449 Patapsco St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1449 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE J. HENNESSY

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John J. Hennessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary R. Newman
15. Birthplace Baltimore

16 (a) Informant Miss Rebecca A. Hennessy
(b) Address 1449 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Brooklyn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 13 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1948 to Oct 11 1948 and that I last saw h[im] alive on Oct 11 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 2 days
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 224 Allendale Date signed 10/12/48

VS 130

G67616 ✓ G67616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILA VICTORIA HICKS

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 22, 1889

8. AGE: Years	Months	Days	If less than one day
59	7	20	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Morris
15. Birthplace Va.

16 (a) Informant Clarence Hicks
(b) Address 2534 McCulloh Street

17 (a) Burial (b) Date thereof 10/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Cedar Hill, Maryland

18 (a) Funeral director Charles [illegible], La
(b) Address 302 Madison Avenue

(a) OCT 12 1948 (b) Huntington Hollins Mortuary
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1948 to Oct 12 1948
and that I last saw her alive on Oct 11 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	2 mos.
Due to Cardio Vascular Disease	1 yr.
Due to Hypostatic Pneumonia	1 day.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Tracy M. D.
Address 1928 Pennsylvania Ave Date signed 10/12/48

X

VS 150

66761?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 66761?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROLAND WILKERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Edna Mary Wilkerson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	-	29		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business McCormick Coal Co.

FATHER
12. Name Perry Wilkerson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Sims
15. Birthplace Maryland

16 (a) Informant Edna Mary Wilkerson
(b) Address 1520 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (Date received) (Registrar) Huntington Williams M.D. Registrar

OCT 13 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 8 p.m.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at approx. 5 p. M.
(b) Where did injury occur? 1520 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Open on stove, on but unlit

23. Signature Earl L. Kay M.D. Medical Examiner
Date signed October 12, 1948

ES-G67618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Florence L. Rous - FLORENCE L. ROUS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 13, 1878

8. AGE: Years 70 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James A.
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Brandt
15. Birthplace Md.

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 14/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

OCT 13 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1933, to 10-12 1948, and that I last saw her alive on 10-12 1948.

Immediate cause of death: Unknown — Duration:
Due to Bronchopneumonia? 2 wks ?
Due to ACVD
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address Date signed 10-12-48

X

G67619

G67619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. _____

BC-KE-29241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 min
(e) Length of stay in Baltimore (yrs., mos., or days) 8 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Chesley Ave, #6
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Preisinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 Oct 48

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 8 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newborn.

11. Industry or business

FATHER
12. Name Robert H Preisinger
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Thelma R Hatton.
15. Birthplace Balto., Md.

16 (a) Informant mother.
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14th 1948 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E North Ave Ext

18 (a) Funeral director Lee G. Lamb
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Registrar (b) Date received Oct 18 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Oct 1948, at 10 06 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Oct 1948 to 12 Oct 1948, and that I last saw him alive on 12 Oct 1948.

Immediate cause of death Congenital Atelectasis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Congenital Atelectasis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert F. Schoenthaler M. D.
Address Maryland Gen Hosp Date signed 13 Oct 48

VS 100

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667620 94a 667620

Registered No.

667620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 Wilmont Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Wilmont Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET ROLFE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William J. Rolfe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1876

8. AGE: Years	Months	Days	If less than one day
72	9	10	hr. min.

9. Birthplace Gloverville, New York
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name John F. Burns
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. George R. Rolfe
(b) Address 924 Wilmont Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16,48 (month) (day) (year)
(c) Cemetery or crematory Riverside Cemetery
Location Rochester, N. Y.

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St.

OCT 13 1948 (Date rec'd by registrar) Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at 6.01 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed October 13, 1948

G67621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67621 Registered No. 1176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 3
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 829 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE E. PENN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Harry Penn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 1881

8. AGE: Years 67 Months Days 3 If less than one day hr. min.

9. Birthplace Balto Co. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Daniel B Hilter
13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth A Burke
15. Birthplace Maryland

16 (a) Informant Daniel B Hilter (brother)
(b) Address 3543 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15-1948 (month) (day) (year)
(c) Cemetery or crematory Bethlehem
Location Reliltz Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
Huntington Baltimore, Md.

OCT 13 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948, at 7:54 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/8 1948 to 10/12 1948 and that I last saw h[illegible] alive on 10/12 1948

Immediate cause of death Pericolic abscess

	Duration
Due to Perforated duodenal ulcer	
Due to Generalized peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/11 1948
Major findings of operation: Perforated duodenal ulcer, peritonitis.
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Hawkins Jr. M.D.
Address Franklin Square Hosp. Date signed 10/13/48

VS 150

667622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

667622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write (R) and give town)
(d) Street No. 525 S. Newkirk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Deuel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-8-07

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41	6	5		

9. Birthplace New York (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name	Dan Deuel
13. Birthplace	New York
MOTHER 14. Maiden Name	Louise Vanderpool
15. Birthplace	Florida

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/48 (month) (day) (year)
(c) Cemetery or crematory St Annis
Location Annapolis Md

18 (a) Funeral director C. H. Hopkins & Son
(b) Address Annapolis Maryland

19 (a) Date received by registrar OCT 18 1948 (b) Registrar's signature Lexington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 8 26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948, to 10/13 1948, and that I last saw him alive on 10/13 1948

Immediate cause of death	Duration
Craniopharyngeomathid Ventricle	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 12, 48
Major findings of operation: large tumor Third ventricle (1)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature George B. Cultrett
Address Johns Hopkins Hospital Date signed Oct 13, 48 M D

X

667623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 667623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: U.S. Marine Hospital 26th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Luckton

3 (b) If veteran, name war, World War #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Batrin Luckton
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) August 29, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	13/14	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Retired

FATHER
12. Name Prokief Luckton
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory United States Nat.
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 12 00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sulmeski M.D. Medical Examiner.
Date signed 10/12/48

VS 151

G67624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. County
(c) City or town Shelton (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Cantini

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-25-43

8. AGE: Years 4 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Francis Cantini
13. Birthplace Texas

MOTHER 14. Maiden Name Mary Delmastro
15. Birthplace Conn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Shelton
Location Shelton, Conn.

18 (a) Funeral director Ullmer Funeral Home
(b) Address 200 Orleans St

19 OCT 14 1948 (Date rec'd by registrar) Huntington Williams M.D. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1948 at 4 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 12 1948 to Oct 13 1948 and that I last saw h[illegible] alive on Oct 13 1948.

Immediate cause of death: Shock — Duration

Due to: Post operative

Due to: Congenital Heart Lesion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 13, 1948

Major findings of operation: Patent Ductus Arteriosus

Date of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature D.L. Cooley M.D.
Address J.H. Hospital Date signed Oct 13 '48

VS 150

67625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G67625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Cherry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife James W. H. Cherry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 5-1897

8. AGE: Years 6 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pete Patrick
13. Birthplace Ohio

MOTHER
14. Maiden Name Nina Drummond
15. Birthplace Ohio

16 (a) Informant James W. H. Cherry
(b) Address 1005 Fulton Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto Co.

18 (a) Funeral director Samuel W. Cullison
(b) Address 1211 N. Arlington Ave

19 Date received 1948 Registrar Huntington Williams M.D. Registrar

OCT 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1948 to 10/12 1948.
and that I last saw h[illegible] alive on 10/11 1948

Immediate cause of death: hypertensive cardio-renal disease
Due to (cardiac failure)
Duration: sev. yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature RAYNER BROWNE, M.D.
Address 1500 EAST MADISON ST.
BALTIMORE, MD.
M. D.
Date signed 10-12-48

VS 159

667626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 667626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4323 Glenmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. HAINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Joanna Fossett
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 5/25/1866

8. AGE: Years	Months	Days	If less than one day
82	4	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name David H. Haines
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Dehl
15 Birthplace Maryland

16 (a) Informant J. Harold Wells
(b) Address 4323 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 14 48 (month) (day) (year)
(c) Cemetery or crematory Taylorsville
Location Taylorsville, Maryland

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31

19 OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Oct 1948 and that I last saw h[illegible] alive on Oct. 11 1948.

Immediate cause of death Heart Failure — Duration 1 Day

Due to Myocardia Insufficiency — 2 weeks

Due to Arteriosclerotic Cardio Vascular disease — 1 year

Other Conditions ~~Etc~~ Incontinence, Senile — 1 Day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which)
(e) Means of injury

23. Signature [illegible]
Address 403 S. Wolfe St. Date signed Oct 14 1948 M D

VS 159

667627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82C

667627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Erdman Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Le roy Haslup.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-28-5523

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary Ellen Haslup
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr) Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	9	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Hardware business
11. Industry or business

FATHER 12. Name Le roy F. Haslup.
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Margaret Washington
15. Birthplace England

16 (a) Informant Mrs. Charles Le Roy Haslup (son)
(b) Address 2830 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct/13/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave. Corner Huntington Ave. Baltimore, Md.

1948 OCT 14 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct 12 1948 and that I last saw him alive on Oct 12 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	2 days
Due to Arteriosclerosis, generalized	years
Due to	
Other Conditions old myocardial infarction	

(Include pregnancy within 3 months of death)

Date of operation Oct 12, 1948
Major findings of operation: [redacted]
of autopsy: As above - Head not permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. F. Cox, M.D.
Address Union Memorial Hosp. Date signed 10-12-48

VS 150

G67628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Hurley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rose Grossman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Louis Grossman
(b) Address 2612 Hurley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship

18 (a) Funeral director Jack Kevy Inc
(b) Address 2106 Eutaw Place

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington-Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1948, at 3:18 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3 1948 to 10/13 1948, and that I last saw her alive on 10/13 1948.

Immediate cause of death	Duration
Uremia	
Due to Chronic Pyelonephritis	
Due to	
Other Conditions Hypertension Cardiovascular Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Copper M. D.
Address Sinai Hospital Date signed 10/13/48

VS 150

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G67629

BALTIMORE CITY HEALTH DEPARTMENT

MAIAMcd CERTIFICATE OF DEATH 94a

G67629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Waldorf ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Waldorf ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Julius Mulamud

3 (b) If veteran, name war ~~served~~ U.S. Army Ret. during peace
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	married

6 (b) Name of husband or wife Mrs. Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1865

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Russia - Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Cleaning & repairing

FATHER
12. Name Isar Mulamud
13. Birthplace Poland

MOTHER
14. Maiden Name Golda Mulamud
15. Birthplace Poland

16 (a) Informant Bessie Mulamud
(b) Address 2807 Waldorf ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 760 Eutaw Place

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948, at 9:36 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 13 1948 and that I last saw him alive on Oct 13 1948.

Immediate cause of death	Duration
Complete Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Nadler M.D.
Address 2306 Eutaw Pl Date signed 10-13-48

VS 150

Physicians: please write the causes of death clearly and legibly. Every item important. Every question answered or satisfactorily supplied.

67630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 67660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BARNEY Gold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Reba
15. Birthplace Russia

16 (a) Informant Joseph Gold
(b) Address 1925 No Druidland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc.
(b) Address 200 Eutaw Place

19 (a) OCT 14 19[illegible] (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 12:17 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/12 1948 to 10/12 1948 and that I last saw him alive on 10/12 1948.

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide No Evidence
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Gotter M.D.
Address Sinai Hospital Date signed 10/12/48

VS 150

Please write the causes of death clearly and legibly. The information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

667631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667631
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Ruben Jacks
13. Birthplace Latvia

MOTHER 14. Maiden Name Bluma
15. Birthplace Latvia

16 (a) Informant Hyman Smith
(b) Address 940 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) (b) Huntington Williams Mort
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 13 - 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to 10/13, 1948.
and that I last saw her alive on 10/3/48

Immediate cause of death Myocardial Failure
Myocarditis

Due to Senile Degeneration, arteriosclerosis

Due to

Other Conditions Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

Duration 7 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Goldman M. D.
Address 1 West Mount St Date signed 10/14/48

OCT 15 48

VS 150

676632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 B

Registered No. 676632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Lyndale Home
(b) Street address — Belvedere & Greenspring Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 48

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lyndale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP MENDEL NEWHOUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Jacob Newhouse
13. Birthplace: Russia

MOTHER
14. Maiden Name: Esther ?
15. Birthplace: Russia

16 (a) Informant: Mrs Elsie Goldberg
(b) Address 3216 Fredneck ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodale Cemetery
Location Rodale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 (a) [illegible] (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 11 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to October 13 1948, and that I last saw him alive on October 13 1948.

Immediate cause of death: Cerebral thrombosis — Duration

Due to: Cerebral arteriosclerosis

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Lyndale Home Date signed 10/13/48

VS 150

X

G67633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67433

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The name of informant should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1825 EDMONDSON AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1825 Edmondson Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUSSELL JAMES HARPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1898

8. AGE: Years	Months	Days	If less than one day
50	4		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Harper.

13. Birthplace St Mary Co. Md.

MOTHER 14. Maiden Name Mary Handy

15. Birthplace Baltimore, Md.

16 (a) Informant Ernest Harper.

(b) Address 1825 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.

Location

18 (a) Funeral director Mrs. Katy K. Williams

(b) Address 322 N. Schroeder St

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington & Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at 6:40AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1948, to Oct. 12, 1948, and that I last saw him alive on Oct. 12, 1948.

Immediate cause of death HYPERTENSIVE CARDIO-RENAL DISEASE — Duration

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas W. Harris M. D.

Address 1924 W. FRANKLIN ST. Date signed 10-12-48

VS 180

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ROBERT ASHBY

3 (b) If veteran, name war: World War 2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1912

8. AGE: Years	Months	Days	If less than one day
36 35	7	27	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Ashby
13. Birthplace 1202 Edmondson Ave.

MOTHER
14. Maiden Name Elizabeth Franklin
15. Birthplace Va.

16 (a) Informant: Wm. Ashby
(b) Address 1202 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 5500 Frederick Ave

18 (a) Funeral director Joseph S. Lord Jr.
(b) Address 1304 N. Carrollton Ave

19 (a) OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 2:35PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of right Femoral artery
Due to
Fracture of neck.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 9/48 at approx. 2:30 P.M.
(b) Where did injury occur? Front of 903 Madison Ave. on the Sidewalk
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Sharp instrument

23. Signature Thos. S. Kenedy M.D. Medical Examiner.
Date signed 10/13/48

667635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 667635 Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 Betsy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Monti, MARGARET A

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Anthimio Monti 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1870

8. AGE: Years 78 | Months 3 | Days 21/4 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Vito [redacted] Pelligrino
13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Scarfo
15. Birthplace Italy

16 (a) Informant Mrs L. Marco
(b) Address 3528 Carlson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Krause Funeral Home
(b) Address 1216 E. Chase St

19 (a) (Date received by Registrar) OCT 14 1948 (b) Huntington Hollins, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11, 1948 at 9:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 5 1948 to Oct 11 1948, and that I last saw he alive on Oct 11 1948

Immediate cause of death	Duration
Pulmonary embolism	
Due to Pelvic thrombophlebitis	
Due to	
Other Conditions Uremia, Myocardial damage, Peritonitis	

(Include pregnancy within 3 months of death)

Date of operation 10-6-48

Major findings of operation: Strangulated abdominal hernia, gangrene appendix

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Schrock M D
Address Franklin Sq Hosp Date signed 10-11-48

100R

667636

667636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 E. FAYETTE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 E. FAYETTE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA FABISZAK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED.

6 (b) Name of husband or wife JOHN FABISZAK.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
98	11		hr. min

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business OWN HOME

FATHER
12. Name FRANK, UNKNOWN
13. Birthplace POLAND.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant FLORENCE UTTENREITHER
(b) Address 2005 E. FAYETTE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Dorman Hill Rd.

18 (a) Funeral director F. W. Ogonowski
(b) Address 1930 Eastern Ave.

OCT 14 1948 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 12 1948 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1948 to Oct. 11 1948 and that I last saw h[illegible] alive on Oct. 11, 1948

Immediate cause of death: Acute Myocardial Insufficiency
Due to: Chronic Myocarditis
Due to: Acute Arteriosclerosis
Due to
Other Condition: Carcinoma of Stomach

Duration: Acute ? Chronic

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/14/48 M.D.

G676537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G676537

Registered No. 12a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12 S Williams St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 12 S Williams St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John C. Kavanaugh

3 (b) If veteran, name war: None Not 1

3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose M. Hunt

6 (c) If alive, give age years

7. Birth date of decreased (mo., day, yr.): 12/7/1896

8. AGE: Years: 51 | Months: 10 | Days: | If less than one day: hr. min.

9. Birthplace: La Salle Ill.

(Town, county, and state)

10. Usual Occupation: Fireman

11. Industry or business: Baltimore City

FATHER — 12. Name: John Kavanaugh

13. Birthplace: Ill

MOTHER — 14. Maiden Name: Mary Tyler

15. Birthplace: Penn

16 (a) Informant: Mrs J. C. Kavanaugh

(b) Address: 12 S Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10 Oct 48 (month) (day) (year)

(c) Cemetery or crematory: Holy Cross

Location: Ritchie Highway

18 (a) Funeral director: J. J. Lakey & Sons

(b) Address: [illegible]

19 OCT 14 1948 (Date rec'd by registrar) (b) Registrar

VS 1-50

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948 at — M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 1948 to 10/12 1948 and that I last saw him alive on 10/12 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Cerebral Hypertension — 2 weeks

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: O. B. Wells M. D.

Address: 1279 Williams St Date signed: 10/14/48

G676538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G676538 Registered No.

124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Elmtree Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Elmtree Street (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME WALTER CHOJNOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	white	married

6 (b) Name of husband or wife May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1904

8. AGE: Years	Months	Days	If less than one day
44	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pipe Corker
11. Industry or business City employee

FATHER
12. Name Walter Chojnowski
13. Birthplace Poland

MOTHER
14. Maiden Name Salamina ?
15. Birthplace Poland

16 (a) Informant Mary Chojnowski
(b) Address 1511 Elmtree St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fralkowski
(b) Address 2007 Eastern Ave.

19 (a) Huntington Williams, M.D. (Registrar)
(b) Registrar

14 vs 1910

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1948, 9.00a.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.
Fatty degeneration of liver

Due to

Other Conditions History of chronic alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed October 14, 1948

G67633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1379 Binder Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April

8. AGE: Years 34 | Months 6 | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Martin
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Smith
15. Birthplace S. C.

16 (a) Informant: Lucilue Martin
(b) Address 613 S. Charles Stree

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.M.E. Co Md

18 (a) Funeral director Isaiah L Brannon
(b) Address 1050 Montgomery St Huntington Williams, Md

19 OCT 14 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at 10.00PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Auricular Fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl M. Long M.D.
Medical Examiner

Date signed 10-13-48

VS 151

657640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances O. Garber

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/48

8. AGE: Years	Months	Days	If less than one day
0	0	12	hr. min.

9. Birthplace Frederick md (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Wilbur Garber
13. Birthplace md

MOTHER
14. Maiden Name Middaed Bentzel
15. Birthplace md

16 (a) Informant Wilbur Garber
(b) Address New Windsor, md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Wingarmore
Location Unionville, Fred. Co. md.

18 (a) Funeral director C. M. Wantz
(b) Address Winfield Md.

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Entering for Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1948 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/14 1948, and that I last saw h alive on 10/14 1948.

Immediate cause of death	Duration
ASPIRATION PNEUMONIA	
PERITONITIS	
Due to GASTRO Stomy	
Due to TRACH Esophageal FISTULA	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature J L Afonte
Address Mercy Hosp Date signed 10/14/48
J. L. AFONTE, M.D.

G67642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 Hampden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 HAMPDEN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Fahey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife MICHAEL J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21 1883

8. AGE: Years 64 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and State)

10. Usual Occupation HOUSEWIFE

11. Industry or business SELF

FATHER
12. Name SAMUEL BLAKE
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name MARY CAVANAUGH
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS ALICE McCAFFERY
(b) Address 326 W. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Wm Cookelman
(b) Address 1217 St. Paul St.

19 (a) OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1948, at 8:30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kopsch M.D. (Medical Examiner)
Date signed Oct 13, 1948

VS 151

G67642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 67[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Winchester Street
(c) Hospital or institution:
16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MAGDLEN EDELEN

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife James A. Edelen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1862

8. AGE: Years	Months	Days	If less than one day
86	5	5	hr. min.

9. Birthplace Bryantown, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Farrall
13. Birthplace Bryantown, Md.

MOTHER
14. Maiden Name Elizabeth Langley
15 Birthplace Bryantown, Md.

16 (a) Informant Mr. James L. Edelen
(b) Address 2907 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Bryantown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948 at 1:55p M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1944 to Oct 13 1948.
and that I last saw her alive on Oct 13 1948.

Immediate cause of death	Duration
Edema of lungs	18 hrs
Due to Failing circulation	1 wk
Due to Arterio sclerosis	10 yrs +
Other Conditions Hypertension	20 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo A. Wells M. D.
Address 4100 Edmondson Ave Date signed 10/14/48

VS 193

G67643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 937

Registered No. G67643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapelgate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Braddock Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDGAR STONEBRAKER McCARDELL

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Abby T. Barnes McCardell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1875

8. AGE: Years	Months	Days	If less than one day
73	8	2	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Self

FATHER
12. Name Adrian C. McCardell
13. Birthplace Williamsport, Md.

MOTHER
14. Maiden Name Alforetta Knode
15. Birthplace Washington Co., Md.

16 (a) Informant Mr. Lee McCardell
(b) Address 4618 Wilmslow Rd., Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director HENRY E. CARTY CO.
(b) Address Frederick, Md.

19 (a) OCT 14 1948 (b) [illegible] Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to October 14 1948, and that I last saw h/M alive on October 13 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Senility	?
Due to Arteriosclerosis, high blood pressure; chronic myo carditis with degenera	?
Other Conditions t, in	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 10/14/48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Burke

Registered No. G67644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 White Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 White Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JEFFERSON BROOKS, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mazie M. Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1886

8. AGE: Years	Months	Days	If less than one day
61	10	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Gen'l. Supt.
11. Industry or business Riggs Distler

FATHER
12. Name John T. Brooks
13 Birthplace Md.

MOTHER
14. Maiden Name Annie Reed
15 Birthplace Md.

16 (a) Informant Mrs. Mazie M. Brooks
(b) Address 4606 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Entered for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/1948, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946, to 10/14 1948, and that I last saw h him alive on 10/11 1948.

Immediate cause of death Cerebral Hemorrhage — Duration one hour.

Due to Hypertensive cardiovascular disease.

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopay:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature D. J. Battaglia M.D. M D
Address Belair Rd. Fullerton Date signed 10/14/48

VS 150

Fold here to detach and mail. Write clearly and legibly.

G67645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G67645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124
(c) Hospital or institution: DOA West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 N. Calvert St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Johanna Hofmeister

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles T. Hofmeister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 Feb. 1862

8. AGE: Years 86 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Trendel
13. Birthplace Germany [redacted]

MOTHER
14. Maiden Name Johanna Stout
15. Birthplace Germany

16 (a) Informant Miss Dorothy Hofmeister
(b) Address 2711 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 14 1948 (b) [signature] Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Oct. 1948, at 5:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐, or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 13 Oct. 1948

VS 151

667646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667646 Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dubiland + Rayner
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County –
(c) City or town Harrisburg, Pa (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Derry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Tillie Katzen

3 (b) If veteran, name war –
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Barnet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace [Europe] Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business –

FATHER
12. Name Simon
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Hyman Bernstein
(b) Address 1206 Derry St. Harrisburg Pa

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory
Location Harrisburg Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 2150 Eutaw Place

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1948, at 2 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948 to 10/14 1948 and that I last saw h[illegible] alive on 10/14 1948.

Immediate cause of death Cerebral Vascular accident — Duration

Due to. Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address WBGH Date signed 10/14/48

VS 150

667647

ES- 123727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

929

Registered No. 667647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5524 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Weintritt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Sophia
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 4, 1871

8. AGE: Years 77 | Months 0 | Days 10 | If less than one day: hr min.

9. Birthplace Vienna Austria
(Town, county, and state)

10. Usual Occupation Grave Attendant

11. Industry or business Holy Redeemer Cemetery

FATHER
12. Name Frances Weintritt
13. Birthplace ? Austria

MOTHER
14. Maiden Name Katherine Putz
15. Birthplace ? Austria

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 19 48, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 19 48 to 10-14 19 48, and that I last saw h im alive on 10-14 19 48

Immediate cause of death: Postemyocardial infarction — Duration 24 hrs

Due to: Hypertensive-Arteriosclerotic Heart Disease — 5 yrs

Due to:

Other Conditions: Cerebral thrombosis with left hemiplegia — 24 hrs.
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.

23. Signature William H. Kushner Jr.
Address Balto City Hosp Date signed 10-15-48

VS 150

67648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2845 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2845 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Strube

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Gustav Strube

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 27th 1866

8. AGE: Years	Months	Days	If less than one day
81	9	17	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Grosse
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Ritter
15. Birthplace Germany

16 (a) Informant Mrs Claire S. Schradieck
(b) Address 2845 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 15 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14th 1948, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to Oct 14 1948, and that I last saw her alive on Nov 14 1947

Immediate cause of death	Duration
Coronary thrombosis	3 hours
Due to Arteriosclerosis	10 years
Due to	
Other Conditions Pernicious anemia	10 years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify)
(e) Means of injury

23. Signature Alan Bernstein M. D.

Address 110 9 N Calvert St Date signed 10/14/48

VS 150

G67649 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G67649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Dunlop B.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/48

8. AGE: Years | Months | Days | (If less than one day) hr. 5 min.
1 27h

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Dunlop
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park

18 (a) Funeral director
(b) Address

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948 at 7:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/19 1948 to 10/19 1948, and that I last saw him alive on 10/19 1948

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris Nyman M. D.
Address 7 Hill Date signed 10/21/48

VS 150

X

667650 SC - 48-21948 ✓ 667650

JL - 123474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 W. Mosher St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy-Lewis - Ruth Ann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1948.

8. AGE: Years	Months	Days	If less than one day
		2	hr min

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Zollie Long

13. Birthplace Md.

MOTHER

14. Maiden Name Ruth Ann Lewis

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 10-7-48 At 9.00 A.M.

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory B.C.H.

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) OCT 15 1948 (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 4.45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 3 1948 to Oct. 5 48, and that I last saw him alive on Oct. 5, 1948

Immediate cause of death. Premature

Duration 2d (4h)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William P. Kean M. D.

Address Balto City Hosp. Date signed 10-6-48

VS 150

G67651 BC-48-28988

BALTIMORE CITY HEALTH DEPARTMENT

AB-123299

CERTIFICATE OF DEATH 159

Registered No. G67651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gillis-Twin "A"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27-1948

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Preston Gillis
13. Birthplace ?

MOTHER
14. Maiden Name Dorothy Commodore
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-29-48 At 9.00 AM (month) (day) (year)
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28- 1948 AM 10.30

21. I certify that death occurred on the date above stated, that I attended deceased from 9-27- 1948 to 9-28- 1948 and that I last saw h im alive on 9-28- 1948.

Immediate cause of death Prematurity — Duration 1 hr (Life)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-6-48

X

G67652

AB-122122 BT- 21070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G67652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Galaway, W. Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bise

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14- 1948

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Izie Mae Bise
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/7/48 at 9 a.m. (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at 5.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1948 to 9-27- 1948, and that I last saw her alive on 9-27- 1948

Immediate cause of death Pneumonia — Duration 1 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-8-48

VS 159

G67653 BC-48-22223 ✓ G67653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

The supplying information called for on this certificate is required by law. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 North Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Jones (100842)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negroe | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-48

8. AGE: Years | Months | Days | If less than one day: hr. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Nathan Forster
13. Birthplace Maryland

MOTHER 14. Maiden Name Audrey Moore
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1948 to Oct. 6 1948, and that I last saw her alive on Oct. 6 1948.

	Duration
Immediate cause of death: Atelectasis	
Due to: Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Bunn M. D.

Address The Johns Hopkins Hospital Date signed 10-7-48

VS 150

67654 SC-48-21540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 67654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Barclay, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Partlow (Partlow)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 15 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Partlow

13. Birthplace ?

MOTHER 14. Maiden Name Lenia ?

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 9- 1948 at 4 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1948 to 10-9 1948 and that I last saw him alive on 10-9 1948.

Immediate cause of death: Cerebral hemorrhage ? Stasis ? cardiac Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury

23. Signature John J. Ryan, M.D.
Address Johns Hopkins Hosp. Date signed 10-10-48

VS 150

G67655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. G67655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Laurel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-6-48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin ? Thomas
13. Birthplace

MOTHER 14. Maiden Name Lula ? Woody
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 11 25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1948 to 10/10 1948 and that I last saw h[illegible] alive on 10/10 1948

Immediate cause of death: Atelactasis

Due to: Prematurity

Due to:

Other Conditions: Cerebral Haemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Hamq M. D.
Address Johns Hopkins Hosp Date signed 10-11-48

VS 150

159

667656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1223

Registered No. 667656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dunn Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Lyon
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Albert Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years 63 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Mary E. Campbell

15. Birthplace Washington D.C.

16 (a) Informant Mrs. Glenda Dudley

(b) Address 623 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 1918 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs. Frances E. Howard

(b) Address 578 W. Biddle St. Baltimore, Md.

19 OCT 15 1918 (b) 6
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1918 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1918 to 10/13 1918 and that I last saw her alive on 10/13 1918.

Immediate cause of death: Complete interstitial Pneumonia — Duration

Due to Indeterminate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature E. C. Walden-Lyon M. D.

Address 1701 Eutaw Pl. Date signed 10/14/18

VS 193

E. C. Walden-Lyon

67657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 67657

Type or print the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1541 Light Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MIRANDA L. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-11-1884

8. AGE: Years	Months	Days	If less than one day
64	8	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name	Isaac Manning
FATHER — 13. Birthplace	Balto
MOTHER — 14. Maiden Name	Louisa Barwick
MOTHER — 15. Birthplace	Md

16 (a) Informant Roland Wilson
(b) Address 1541 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge, Md.

18 (a) Funeral director George D. Farley
(b) Address Fulton and Fayette Sts. Huntingtown Williams, Md.

19 OCT 15 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1948 to 10-13 1948 and that I last saw her alive on 10-13 1948

Immediate cause of death: Pulmonary Edema — Duration: 3 days
Due to: Cardiac Decompensation — 4 hrs
Due to: Hypertensive Cardiovascular Disease — 10 yrs
Other Conditions: Carcinoma of Uterus, Lupus, Rigal Thigh
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CVD - Decompensation Ca of Uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Newell M. D.
Address 1213 Light St. Date signed 10-15-48

VS 155

576:58 BC - 48 - 22065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66726:48 11012

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church home + hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No 2803 Liberty Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Harris

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/29/48

8. **AGE:** Years 0 | Months 0 | Days 0 | If less than one day 0 hr. 45 min.

9. Birthplace Church Home + Hospital Balt. 31 Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Newborn

FATHER
12. Name Sterling Harris
13. Birthplace ?

MOTHER
14. Maiden Name Rosalee Grooms
15. Birthplace Virginia

16 (a) Informant mother
(b) Address 2803 Liberty Parkway Dundalk 29 Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 9/30/48 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11:15 PM 9/29 1948 to 12 M 9/30 1948, and that I last saw her alive on 12 M 9/30 1948.

Immediate cause of death	Duration
atelectasis	
Due to bilateral pleural effusion	
Due to unknown (Hydrops fetalis)	
Other Conditions peritoneal effusion	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home + Hosp. Date signed 9/30/48

VS 150

67659 BC-48-10463 ✓ 67659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 67659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THERESA MAE COATES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1948

8. AGE: Years | Months: 6 | Days: 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lorenzo Brodie, Jr.
13. Birthplace Franklin Co., N.C.

MOTHER
14. Maiden Name Margaret Coates
15. Birthplace Calvert Co. Md.

16 (a) Informant: Margaret Coates
(b) Address 1504 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3229 W. Lombard St.

19 (a) OCT 15 1948 (Date received by registrar) (b) Lurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948 .8 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Uppper Respiratory Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 10/13/48

VS 151

67760 Ba-48-22083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. 67760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St (18)
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Wilmington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Batch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Five hours 10/7/48

8. AGE: Years | Months | Days | If less than one day 5 hrs. 2 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy Batch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jessie Rena Davison
15 Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 11 1948
18 (a) Funeral director Commissioner of Health
(b) Address
OCT 15 1948
19 (a) (Date rec'd by registrar) (b) Filed Baltimore, Md.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948 at 34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948 to 10-8 1948 and that I last saw h alive on 10-8 1948

Immediate cause of death Hydrocephalus
Due to Congenital
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M. D.
Address 876 Wilmington Ave. Date signed 10/11/48

667661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

667661
Registered No.

1. PLACE OF DEATH:
(a) Baltimnre City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution: Beach Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE HOWARD RILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1872

8. AGE: Years	Months	Days	If less than one day
76	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

PARENTS
12. Name Benjamin Clay Howard Riley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Jane Hamilton
15 Birthplace Seaford, Delaward

16 (a) Informant Miss Bertha Creamer
(b) Address 1008 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 15 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 13 1948, and that I last saw her alive on Oct 12 1948.

Immediate cause of death: Cerebral Hemmorhage — Duration: 5 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Evl Smith
Address 1223 E North Ave Date signed 10/14/48 (M) (D)

67662 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. 67662

CERTIFICATE OF DEATH 49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Caton Ave. at Monastery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Caton Ave. at Monastery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY THERESA ROSENBERGER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-10-7139

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1879

8. AGE: Years 69 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Hochschild, Kohn & Co.

FATHER
12. Name Appolina Rosenberger
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhelmina Karl
15. Birthplace Md.

16 (a) Informant Mr. Charles W. Altvater
(b) Address 3603 Caton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1948, to Oct. 14, 1948, and that I last saw her alive on Oct. 13, 1948.

Immediate cause of death: Carcinoma of lungs — Duration: 10 mo
probably of ovarian origin
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kump M. D.
Address 3030 Edmondson Ave. Date signed 10/15/48

VS 150

Enter age if especially important. Physicians: please write the causes of death clearly and legibly. Sign only if you have personal knowledge of the facts stated, and after last illness.

667663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121a

Registered No. 667663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Brighton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE KATE ASKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife William C. Askins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1867

8. AGE: Years	Months	Days	If less than one day
81	3	14	hr. min.

9. Birthplace Warsaw, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard R. Webb
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie A. Yeatman
15. Birthplace Virginia

16 (a) Informant Mr. William C. Askins, Son
(b) Address 3004 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 15 19.. (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 19 48 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Oct 14 1948, and that I last saw h alive on Oct 6- 1948

Immediate cause of death Coronary occlusion — Duration 7 hrs

Due to Arteriosclerosis — 5 yrs

Due to Chr. nephritis — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. McDermott M. D.
Address 1136 Poplar Gun St. Date signed 10/15/48

VS 150

67664 ✓ 67664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write clearly and legibly. Use black ink or typewriter. Do not use pencil. If the cause of death cannot be stated definitely, state the conditions which led to death.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 143 W. Henrietta

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 143 W. Henrietta (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Jennie M. McDowell

3 (b) If veteran, name war: War 2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Leda McDowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24-1906

8. AGE: Years 42 | Months 8 | Days 20 | If less than one day: hr. min.

9. Birthplace Macon. Ga.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Neal McDowell

13. Birthplace N.C.

MOTHER 14. Maiden Name Virginia Blank

15. Birthplace N.C.

16 (a) Informant Leda McDowell

(b) Address 143 W. Henrietta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-48 (month) (day) (year)

(c) Cemetery or crematory Sanford. N.C.

Location Lee Co

18 (a) Funeral director James A Hayes

(b) Address 142 W. Hill St

19 (a) OCT 15 1948 (Date received by registrar) (b) Huntington Hillsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1948 at 11.15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10/4/48 19 to 10/14 1948, and that I last saw h alive on 10/14 1948

Immediate cause of death	Duration
Coronary thrombosis	10/14
Due to Myocarditis	
Due to Bronchopneumonia	10/11
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Allen R Hayes M. D.

Address 122 W. Bmore St Date signed 10/13/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G677665

767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No 1 Alexander Ave Catonsville
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lenard Webb Stephens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	negro	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-48

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Enoch Webb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Viola Watkins
15. Birthplace Baltimore, Md

16 (a) Informant Viola Watkins Stephens
(b) Address No 1 Alexander Ave. Catonsville Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School OCT 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 10-11-1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1948, at 1.57 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1948, to 8/9 1948, and that I last saw h im alive on 8/9 1948.

Immediate cause of death	Duration
Asphyxia	
Due to Respiratory Failure	
Due to Undetermined Etiol.	
Other Conditions Congs. Blood Dyscrasia	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sam. H. Rhoads M. D.
Address Provident Hosp Date signed

VS 150

161a 8-20-48

Please write the causes of death clearly and legibly.

67676 BC-48-21776 ✓ 67676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 67676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lenadeau Ave. & Madison St.
(c) Hospital or institution: Maryland Emil Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 North Bay St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Hahn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fe | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Oct. 1948

8. AGE: Years | Months | Days | If less than one day 4 hr. 31 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Boyd Lenore Hahn
13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Abbie Elizabeth Cap
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Hahn
(b) Address 1846 North Bay St. #15

17 (a) — (Burial, cremation, or removal) (b) Date thereof — (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School OCT 14 1948
Location Commissioner of Health

18 (a) Funeral director —
(b) Address —

OCT 4 1948 (Date received) (Registrar) Baltimore Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948 at 10 36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1948 to Oct 3 1948, and that I last saw her alive on Oct 3 1948.

Immediate cause of death Prematurity — Duration

Due to (Mother's prolonged labor and abruptio placenta)

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W C Friday M. D.
Address Maryland Emil Hosp. Date signed 10-3-48

VS 190

Direct type or especially important. Physicians: please write the causes of death clearly and legibly. Information must be carefully supplied.

76623C = 48-18332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G67607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 n Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnette Gwendolyn Fowlkes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/26/48

8. AGE: Years	Months	Days	If less than one day
			24 hr. 10 min.

9. Birthplace Baltimore md (Town, county, and state)
10. Usual Occupation N' Born Infant
11. Industry or business

FATHER
12. Name John Fowlkes
13. Birthplace Crewe Va

MOTHER
14. Maiden Name Lucy mae Gill
15. Birthplace Oxford nc

16 (a) Informant Miss Lucy mae Gill
(b) Address 102 n Eden St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loca Johns Hopkins Medical School OCT 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1948 to 8/27 1948, and that I last saw h[illegible] alive on 8/27 1948.

Immediate cause of death	Duration
Ques Untreatable Convulsions	
Due to Aspiration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Provident Hosp (Date signed)

X 8-30-48

VS 180

Office use is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

67668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 67668 Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 686 Pearse St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 686 Pierce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Blanche Sharp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isaac Sharp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Geo Freman
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Dyson
15. Birthplace Maryland

16 (a) Informant Agnes Thomas
(b) Address 686 Pearse St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Bond Ave

19 (a) OCT 15 1948 (b) Registrar
Received by registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948. at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1948. to Oct. 13, 1948. and that I last saw her alive on Oct. 12, 1948.

Immediate cause of death	Duration
Pulmon. Tuberculosis	3 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 W. Hill Ave Date signed 10-15-48

7669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 16765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City, or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Hawthorne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	Colored	Married	Joseph T	years

7. Birth date of deceased (mo., day, yr.) June 22, 1896

8. AGE: Years	Months	Days	If less than one day
52	3	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER 12. Name	John W Jones
FATHER 13. Birthplace	Md
MOTHER 14. Maiden Name	Mary Jones
MOTHER 15. Birthplace	Md

16 (a) Informant Joseph Hawthorne
(b) Address 415 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County
18 (a) Funeral director Mrs Pott A. Elliott Dyer
(b) Address 1297 N. Carey St

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Oct 12 1948 and that I last saw her alive on Oct 12 1948

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Garland Schindel
Address 1534 Druid Hill Ave Date signed Oct. 13-48

VS. 150

G67670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G67670
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Canton & Milton
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town (and) Daniels, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or (No)
If yes, name country

3 (a) FULL NAME Baby Boy Nealy

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 10-6-48

8. AGE: Years	Months	Days	If less than one day
—	—	—	0 hr. 5 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Luther Nealy
13. Birthplace Penn.

MOTHER
14. Maiden Name Bobbie Burke
15. Birthplace Va.

16 (a) Informant Ophie Nealy
(b) Address Daniels Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Martin Bailey & Sons
(b) Address 1827 W. North Ave.

OCT 15 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1948 at 11:35 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/6 1948 to 10/6 1948.
and that I last saw him alive on 10/6 1948

Immediate cause of death Cardio-Resp failure — Duration
Prematurity (4½ mo)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Elinor M.D.
Address St Agnes Hosp Date signed 10/16/48

G67671 ✓ G67671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 West Balto. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 West Balto Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ottomar Toepfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at 2 10 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of ~~husband~~ or wife TERESA BERTA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 30 1885

8. AGE: Years	Months	Days	If less than one day
63	5	16	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation MACHINIST

11. Industry or business MD. DRY GOOD

FATHER
12. Name ANDREAS TOEPFER
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINA KOCH
15. Birthplace GERMANY

16 (a) Informant MRS OTTOMAR TOEPFER
(b) Address 1328 BALTIMORE AVE

17 (a) BURIAL (b) Date thereof OCT 18 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SALEM LUTHERAN
Location CATONSVILLE MD

18 (a) Funeral director Wm H Wilson
(b) Address 4101 Edmondson Ave

19 (a) OCT 15 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelbert M.D.
Medical Examiner.
Date signed Oct 15, 1948

VS 151

G67672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67672

Registered No. 9-D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~785 Crantley St~~
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 785 CRANTLEY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O'Donnell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ late THOMAS P
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL 29, 1872

8. AGE: Years	Months	Days	If less than one day
76	5	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name PATRICK KANE
13. Birthplace IRELAND

MOTHER
14. Maiden Name BRIDGET ODONNELL
15. Birthplace IRELAND

16 (a) Informant MISS ETHEL ODONNELL
(b) Address 785 CRANTLEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 18 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H Wilkes
(b) Address 401 Edmondson Ave

19 (a) OCT 18 1948 (b) (Registered by registrar) Registrar
Huntington Hillcrest, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1948 at 5-45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/14 1948. and that I last saw her alive on 10/13 1948.

Immediate cause of death Respiratory failure
Due to cerebral damage
Due to arteriosclerotic H. D.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury
23. Signature D O'Connell M. D.
Address Bon Secours Hosp Date signed 10/14/48

667673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

667673

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 W. Lafayette ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Lafayette ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Oliviea Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Sam Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Blunt
13. Birthplace N. C.

MOTHER
14. Maiden Name Sylvia Harvey
15. Birthplace N. C.

16 (a) Informant Horace Blunt
(b) Address 702 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)

(c) Cemetery or crematory Bell Haven
Location Bell Haven N. C.

18 (a) Funeral director Leo H. Nelson
(b) Address 1303 Pennsylvania ave

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington, Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 14 - 1948 at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 2 - 1948, to 10 - 14 - 1948, and that I last saw h alive on 10 - 11 - 1948

Immediate cause of death Convulsions of uremia — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury
23. Signature Leo H. Nelson M. D.
Address 611 N. Carolina Date signed 10-15-48

VH 3

G67674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 67674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Seagull ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Cherry Hill Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Seagull ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Grant

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1993

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 8-1898

8. AGE: Years 50 | Months 6 | Days | If less than one day: hr. | min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business First Nat. Bank

FATHER
12. Name Sandy Grant
13. Birthplace Virginia

MOTHER
14. Maiden Name Cindra Derick
15. Birthplace Culpeper Va

16 (a) Informant Bertha Greene
(b) Address 403 Seagull ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1001 Bl[illegible] ave

19 (a) OCT 15 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1948 to Oct 13 1948. and that I last saw him alive on Oct 12 1948

Immediate cause of death Lobar Pneumonia (unresolved)

Duration 43 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Haines M.D.
Address 507 N Hamburg St Date signed 10/14/48

VS 15

G67675 Vol 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67675 1216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 103 S. Caroline St (If outside city or town limits, write (C) or (T), and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Cornish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-95

8. AGE: Years 53 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Gross
13. Birthplace Md

MOTHER 14. Maiden Name Delia Cottman
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy E. Wilson
(b) Address 1010 Bentley Ave

19 (a) OCT 15 1948 (Must not be registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1948 at 7.01 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948 to 10-13 1948 and that I last saw her alive on 10-13 1948

Immediate cause of death Cardiac failure with pulmonary edema uremia — Duration: 1 hour

Due to hypertensive cardio vascular disease and chronic glomerulo nephritis

Other Conditions Type B Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy Hypertrophied heart and small scarred kidneys

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Calvin Harvey M.D.
Address Johns Hopkins Hospital
Filed 10-13-48

VS 153

657676

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

Registered No. 657676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 E Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME BEATRICE GRAY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Langford Miller
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1908

8. AGE: Years	Months	Days	If less than one day
39	11	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard A. Gray
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Georgia Vinson
15. Birthplace Essex Co., Virginia

16 (a) Informant Langford Miller
(b) Address 1520 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Blankley ave

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntington Millicent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1948, 6.30p.M

21. I certify that I took charge of the remains described above, held an Inspec & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asymptomatic

Due to SYRINGOMYELIA

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed October 14, 1948

VS 1st

667677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12-7a

Registered No. 667677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 W Chase St
(c) Hospital or institution: Lorien Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 522 Normandy ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Henry Zepp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 13-1872

8. AGE: Years 76 | Months | Days 1 | If less than one day: hr. min.

9. Birthplace Hampstead Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Salesman Retired

11. Industry or business Sanitary Co

FATHER 12. Name George W Zepp
13. Birthplace Hampstead Carroll Co

MOTHER 14. Maiden Name Mary Jamison
15. Birthplace Hampstead Carroll Co

16 (a) Informant Mrs Lola W. Zepp
(b) Address Keymar Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17-1948 (month) (day) (year)
(c) Cemetery or crematory Wesley Cemetery
Location Hampstead Carroll Co Md

18 (a) Funeral director Maurice Cook-Lyter
(b) Address 1600 W. North ave.

19 (a) OCT 15 1948 (Date rec'd by registrar) Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-48 19 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1946 to 10-14 1948.
and that I last saw him alive on 10/13 1948

Immediate cause of death	Duration
Terminal Pneumonia —	
Pulmonary edema —	
Due to Bronchopneumonia —	
Due to Uremia —	
Other Conditions Hypertrophy of prostate	2 years

(Include pregnancy within 3 months of death)

Date of operation 10/12/48

Major findings of operation: hypertrophy of prostate

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Walter Edwards, M.D.
Address 39 21 Date signed 10/14/48

VS 150

676678 RAHNIS 676678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200a

Registered No. 676678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Universalty Hospital
(d) Length of stay in hospital or inst. (yrs., mos., days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Cape May. (If outside city or town limits, write RURAL and give town)
(d) Street No. Cape May Rd. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H RAHNIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Emilie Rahnis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 15-1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	1			

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Herman Rahnis
13. Birthplace Germany.

MOTHER
14. Maiden Name Louise Holland
15. Birthplace Balto.

16 (a) Informant Mrs. Emilie Rahnis
(b) Address Cape May Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer.
Location Belair Rd.

18 (a) Funeral director John D Connelly.
(b) Address 48 Eastern Ave. Balto 21.

19 OCT 15 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948, to 10-14 1948, and that I last saw h alive on 10-14 1948.

Immediate cause of death	Duration
Cardio vascular respiratory failure	
Due to Peripheral circulatory collapse	
Due to Cause undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature W. A. Oberndorfer M. D.
Address Universalty Hosp Date signed 10.14.48

VS 150

Dr. E. J. Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

Registered No. 667679

7679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Westfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3010 Westfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERNARD A. SANDKUHLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Clara M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Sandkuhler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Augusta ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Clara Sandkuhler
(b) Address 3010 Westfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date received by Local Registrar OCT 19 1948 (b) Huntington Williams, M.D. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1936 to Oct 14 1948, and that I last saw h alive on Oct 14 1948.

Immediate cause of death Carcinoma of the Prostate with metastases

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration hrs. 1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E. J. Alessi, M.D.
Address 6217 Harford Rd Date signed 10/14/48

VS 150

67680 Keown
1938 Linden Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 67680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Callow Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Callow Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Scholz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	11	20	hr. min.

9. Birthplace Mc Keeskock, Pa. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mildred Mc Mullen
(b) Address 2300 Callow Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Baltimore, Md.

18 (a) Funeral Director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15th 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to 5-Oct 1948, and that I last saw h[illegible] alive on 14 Oct 1948

Immediate cause of death: Cerebral Hemorrhage
Rt Hemiplegia
Due to Hypertensive Arteriosclerotic Cardio Vascular Disease
Due to
Other Conditions Called Gastric
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Oct 2 1948 years ; years

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature Laurence L. Brown Jr. M.D.
Address 1938 Linden Ave Date signed 15 Oct 48

VS 150

BC-48-16492

667681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. 667681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Southern Ave.
(c) Hospital or institution: West Balto. Gen. Hosp. If not in hospital or institution, give residence.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rey SUSAN IRENE REY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/29/48

8. AGE: Years	Months	Days	If less than one day
0	2½	17	hr. min.

9. Birthplace Balto.
(Town, county and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John H Rey
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Emily Ray
15. Birthplace PENNA

16 (a) Informant John Howard Rey
(b) Address 3806 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18, 48 (month) (day) (year)
(c) Cemetery or crematory Woodland
Location Taylor ave Balto. Md.

18 (a) Funeral director Leonard J. Rund
(b) Address 5345 Hamilton Rd.

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Oct 1948 at 3 °A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Oct 15 1948 and that I last saw h[illegible] alive on 15 Oct 1948.

Immediate cause of death Atelectasis & Causes pulmonary aspiration of food.
Due to Causes unknown.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. E. Young
Address W.B.G.H. Date signed 15 Oct 48

VS 150

H 2 5

G67682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. G67682

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 1225 Rustic Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Wiegmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mary E. Wiegmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 96 76

8. AGE: Years	Months	Days	If less than one day
72	2	26	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER 12. Name William Wiegmann

13. Birthplace ? Germany

MOTHER 14. Maiden Name ?

15 Birthplace ? Germany

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem. Location Eastern Ave.

18 (a) Funeral director John G. Miller

(b) Address 2304 Jefferson St.

19 (a) OCT 15 [illegible] Washington Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948 to 10-13 1948. and that I last saw him alive on 10-13 1948.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Retrograde phlebothrombosis	
Due to Cancer of urinary bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 2, 1948

Major findings of operation: Perforation of urinary bladder and peritonitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard F. Kelly Jr

Address Johns Hopkins Hosp. Date signed 10/19/48

VS 130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66[illegible]3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Gwendolyn Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-48

8. AGE: Years	Months	Days	If less than one day
		5-4	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Reid
13. Birthplace Waynesboro, S.C

MOTHER
14. Maiden Name Magola Irag Dixon
15. Birthplace Hightport N.C

16 (a) Informant Magola Dixon
(b) Address 1634 W Lexington St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948, at 7:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1948, to 10-2 1948, and that I last saw her alive on 10-2 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to unknown cause	
Other Conditions Clinical Jaundice	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address University Hosp Date signed 10-5-48

X

67684 C-48-2165 X 159 ✓ 67684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lake Shore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hr. 35 min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Edward Hawkins
13. Birthplace ?

MOTHER
14. Maiden Name Anna Clementine Mary
15. Birthplace Curtis Bay, Md.

16 (a) Informant Anna Hawkins Mother
(b) Address Lake Shore Pasadena, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [redacted] OCT 7 - 1948

18 (a) Funeral director
(b) Address Commissioner of Health

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1948, at 12:~~00~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948, to 10-1 1948, and that I last saw h— alive on 9-30 1948.

Immediate cause of death	Duration
30 week old premature infant.	
Due to Asphyxiation -	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Bole M. D.
Address University Hosp Date signed 10-1-48

VS 150

X

67685 BC-HP-21665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: Univ. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 681 Sarah Anne St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-3-48

8. AGE: Years | Months | Days | If less than one day 6 hr. 40 min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name [illegible] ?

13. Birthplace (Northampton) ?

MOTHER 14. Maiden Name Mary Hall

15. Birthplace Washington, D.C.

16 (a) Informant Mary Hall

(b) Address 681 Sarah Anne St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 7 - 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/48 1948, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1948 to 10-3 1948 and that I last saw her alive on 10-3 1948.

Immediate cause of death Cardio-Resp-Failure

Due to Prematurity

Duration 6 hrs 40 min

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Auld M. D.

Address Univ Hosp Date signed 10-4-48

VS 150

X

67686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-a

Registered No. 67686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: JOHN HINDAS KENNEDY

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Maude (Erdman) Kennedy

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1879

8. AGE: Years	Months	Days	If less than one day
69	8	0	hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Monument

11. Industry or business

FATHER
12. Name Hugh T. Kennedy
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth M. MacLean
15. Birthplace Scotland

16 (a) Informant Mrs. Maude E. Kennedy
(b) Address 2008 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 5:18PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 10/15/48

VS 151

G67687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-B

Registered No. G67687

Please write clearly and legibly. Use black ink or typewriter. Do not use pencil. If the cause of death is unknown, state the fact.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Dukeland
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Booth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Torst

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Married

6 (b) Name of husband or wife Engelbert Torst

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1904

8. AGE: Years	Months	Days	If less than one day
44	5	10	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name George Schmidt
13. Birthplace Germany

MOTHER 14. Maiden Name Margarete Kocher
15. Birthplace Germany

16 (a) Informant Engelbert Torst
(b) Address 2201 Booth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Catonsville Md.

18 (a) Funeral director George A. Kunkel
(b) Address 1401 Frederick Rd

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1948 at 6:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12 Oct 1948 to 14 Oct 1948 and that I last saw h[illegible] alive on 13 Oct 1948

Immediate cause of death	Duration
(a) Mitral Stenosis Rheumatic heart disease.	
Due to (b) Rheumatic fever.	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Confirmatory

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Young M.D.

Address West Balto. Gen. Hosp. Date signed 15 Oct 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 667588

48-225 93 CERTIFICATE OF DEATH

160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern & Wayne Ave
(c) Hospital or institution:
West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5242 Long Point Rd #22 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Horsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Woodrow Horsey
13. Birthplace Ellicott City Md

MOTHER
14. Maiden Name Vivian Mary Taylor
15. Birthplace Ellicott City Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 1948 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1948 to 10/2 1948, and that I last saw h/m alive on 10/2 1948.

Immediate cause of death Intra cranial hemorrhage — Duration 2 days

Due to Unknown cause

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10/2/48

Major findings of operation: X ray head shows spinal fluid on spinal tap

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto. West Balto Date signed 10/3/48

VS 130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. GS76383

BC-48-2385 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raynor Ave
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs 44 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
			5 hr. 31 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Robinson
13. Birthplace Mary-D, Penna

MOTHER
14. Maiden Name Rosemarie Corriere
15. Birthplace Balto, Md.

16 (a) Informant Mrs Rosemarie Robinson
(b) Address 2204 Westwood Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 4 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-48 19 at 9:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-30-48 19 to 10-1-48 19, and that I last saw her alive on 10-1-48 19

Immediate cause of death resp failure — Duration

Due to premature

Due to

Other Conditions Myo fib (1) Hyaline membranes (2) Pulmonary edema
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grayson S Waldorf M. D.
Address WB 24 Date signed 10-1-48

VS 150

67690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 ✓ Registered No. 67690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 South Paca St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Coffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-19-48

8. AGE: Years	Months	Days	If less than one day
	1	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Coffman
13. Birthplace Virginia

MOTHER
14. Maiden Name Beulah Coffman
15 Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 7 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 3 1948, at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948, to 10-3 1948, and that I last saw her alive on 10-3 1948.

Immediate cause of death: Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Galloway M. D.
Address University Hospital Date signed 10-5

VS 199

G67691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G67691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Baltic Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Baltic Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter William Payne

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8956

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Evelyn M. (Clowes)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/1893

8. AGE: Years	Months	Days	If less than one day
55	0	6	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business Locke Insulator Co.

FATHER
12. Name Walter Payne
13. Birthplace Eng.

MOTHER
14. Maiden Name Agnes Lythgoe
15. Birthplace Eng.

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey, Maryland

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) [illegible] (Signature of Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1948, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1948 to 10/13 1948, and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Cerebral Cerebrovascular Thrombosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/[illegible]/48

VS 150

657692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

657692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3527 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 Hayward Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas B. Bowling

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-24-0064

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Lorman M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 6, 1918

8. AGE: Years 30 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Llewellyn Cross
13. Birthplace Carson

MOTHER
14. Maiden Name Mary Spindler
15. Birthplace Balto. Co. Md.

16 (a) Informant Lorman M. Bowling
(b) Address 3527 Hayward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Lemmon & Geiger
(b) Address 5005 York Rd

19 OCT 15 1945 (Date received by local registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1945, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 14 1945; and that I last saw h[illegible] alive on Oct 13 1945.

Immediate cause of death Cerebral Hemorrhage — Duration Sudden

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. de Barbieri M. D.
Address 4723 Park Heights Ave. Date signed 9/15/45

VS 150

G67693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G67693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2634 Matthew Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Sadie A. Dowd.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Matthew F. Dowd.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 26, 1894

8. AGE: Years	Months	Days	If less than one day
54.	7	15	20 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George S Limpert
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Bigan
15. Birthplace Baltimore

16 (a) Informant Records
(b) Address Union Memorial Hospital

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 OCT 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948, at 7:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Oct 15 1948, and that I last saw h[illegible] alive on Oct 15 1948.

Immediate cause of death	Duration
Respiratory Failure	?
Carcinoma of Lung	
Due to Carcinoma of Lung	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hospital Date signed 10-15-48

VS 150

67694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 67694

1. PLACE OF DEATH:
(a) Baltimore City; Maryland
(b) Street address 1911 Harlem Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Harlem Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WYSOR REAVLY WAYNESBORO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Gordon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	15	hr. min.

9. Birthplace Charleston, W. Virginia (Town, county, and state)

10. Usual Occupation Hpusewife

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mr. Gordon Waynesboro
(b) Address 1911 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 10-13 1948. and that I last saw h alive on 10-13 1948.

Immediate cause of death Myocardial Degeneration — Duration 2wk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Lin Ridlon M.D.
Address 1343 Penna. Ave Date signed 10/13/48

VS 153

G 1810

67695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

McKenney 14

Registered No. G67695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Arlington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Henry McKenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 30, 1945

8. AGE: Years	Months	Days	If less than one day
3	0	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation child.

11. Industry or business

FATHER
12. Name John Henry McKenney
13. Birthplace Lowdester Co. North Carolina

MOTHER
14. Maiden Name Viola Gladden
15. Birthplace St Marys Co. Md

16 (a) Informant parents
(b) Address 519 N. Arlington Ave. Balto 23,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Gdns.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) OCT 16 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/48 1948, at 245 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948, to Oct 14 1948, and that I last saw him alive on Oct. 13 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	2 weeks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P.A. Benson M. D.
Address Sydenham Hospital Date signed 10/14/48

V S 150

X

667696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186B

Registered No. 667696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #16 Box 76 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM J. MAGSAMEN

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 215-14-8411

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Virginia M. Magsamen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1924

8. AGE: Years	Months	Days	If less than one day: hr.	min.
23	11	27		

9. Birthplace: Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation: Supervisor Cable Worker

11. Industry or business: Clifton Conduit

FATHER
12. Name: John D. Magsamen
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden Name: Mamie Heinbuch
15. Birthplace: Baltimore Co., Md.

16 (a) Informant: Mrs. Wm. J. C. Magsamen
(b) Address: Golden Ring & Phila. Rds.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory: Zion Luth. Cem.
Location: Stemmers Run, Md.

18 (a) Funeral director: Lassahn Funeral Home
(b) Address: 7401 Belair Road

19 (Date rec'd by registrar) OCT 16 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Compound fracture of skull, Amputation of R. Leg, Hemorrhage

Due to

Other Conditions: Traumatic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/6

(a) Date of injury 10-15-48 at approx. 2.15 P. M.
(b) Where did injury occur? 1625 S. Clinton St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Industrial place While at work? yes
(d) Means of injury Crushed while putting belt in shaft.

23. Signature Emil L. Ruge M.D. (Medical Examiner)

Date signed October 16, 1948

VS 181

67697
ES- 123157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 B

Registered No. 67697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days.
(e) Length of stay in Baltimore, (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Thomas Dixon
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-8718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) May 27, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Deceased Thomas Dixon
13. Birthplace ? Balto. Md.

MOTHER
14. Maiden Name Deceased Lurona Wilson
15. Birthplace Balto. Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore, Md.

18 (a) Funeral director Walter O. Briggs
(b) Address 3 E. Hamilton St.

19 OCT 16 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 1948, at 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948, to 10-9 1948 and that I last saw him alive on 10-9 1948

Immediate cause of death: Pulmonary edema — Duration
Due to: Mitral stenosis
Due to: Rheumatic Heart Disease.
Other Conditions: Ulcerated liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirkin M.D.
Address Balto City Hosp Date signed 9 Oct 48

VS 150

67698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 6678698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rebecca Sprigs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 25, 1870

8. AGE: Years	Months	Days	If less than one day
78	7	16	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mr. Jesse Sprigs
(b) Address 734 W. Franklin St.

17 (a) Burial (b) Date thereof 10-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Mutual-Calvert Co. Md.

18 (a) Funeral director Mrs. Thomas G. Hensley
(b) Address 578 W. Biddle St.

18 OCT 16 1948 Huntington Williams
Date filed by registrar Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 13 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 19 48 to Oct 13 19 48.
and that I last saw him alive on Oct 1 19 48.

Immediate cause of death Cardiac arrest
Due to Nephritis
Due to Hypertension
Other Conditions Senility

Duration
unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Gorme M. D.
Address 1522 Eutaw Pl. Date signed 10-14-48

VS 150

G67699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20E

G67699 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 FOSTER AVE
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE HEIMBACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 16, 1896

8. AGE: Years	Months	Days	If less than one day
52	5	27	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation UNEMPLOYED.

11. Industry or business

FATHER
12. Name Conrad Heimbach
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Muth
15. Birthplace Germany

16 (a) Informant Andrew C. Heimbach, brother
(b) Address 3503 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler, Inc,
(b) Address 403 S. Wolfe Street.

19 (a) OCT 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1948 at 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 13, 1948 to October 14, 48 and that I last saw him alive on October 14, 1948.

Immediate cause of death
Respiratory Failure
Due to Syphiletic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M. D.
Address St. Joseph's Hospital Date signed 10-14-48

VS 150

G67700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 167700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 W. 40th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 W. 40th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth O. Damm

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. Damm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 19, 1858

8. AGE: Years	Months	Days	If less than one day
90	1	26	hr. min.

9. Birthplace Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Conrad Ault
13. Birthplace West Virginia

MOTHER
14. Maiden Name Annie Bosel
15 Birthplace West Virginia

16 (a) Informant Mrs. Alva Hunt
(b) Address 1331 W. 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

OCT 16 1948 (Date rec'd by registrar) (b) Turington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 15, 1948 at 8.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 Oct 15 1948 and that I last saw h CV alive on Oct 15 1948.

Immediate cause of death
Arteriosclerotic CVD
Decomp

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence J. Hunnicutt M. D.
Address 3711 Dalrymple Date signed 10-15-48

VS 150

667701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. LUTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	5	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name --- Sommers
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. George Frank
(b) Address Hill Ave., Box 131, R.F.D. 6 Towson, Md.

17 (a) burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 2101 Belair Road

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/ 1948 to 10/16 1948. and that I last saw h alive on 10/15 1948

Immediate cause of death: Arteriosclerotic cardio-vascular — Duration

Due to Renal

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Groff M. D.
Address 8100 Harford Rd. Date signed 10/16/48

OCT 17 1948 Huntington Williams, M.D.

667702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667702

(927)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5200 McCormick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John D. Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-1890

8. AGE: Years 58 | Months 05 | Days 14 | If less than one day: hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Klein
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Eckmeyer
15. Birthplace Md.

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

(a) 17 1948 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1948, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1948, to 10-16 1948, and that I last saw him alive on 10-10-1948

Immediate cause of death: Hypertensive encephalopathy — Duration: 1 week

Due to: Hypertensive C.V. disease — 5 yr

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp Date signed 10-16-48

VS 150

HLH 43 667703 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667703

CERTIFICATE OF DEATH 157E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Lexington (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 3-18-47

8. AGE: Years	Months	Days	If less than one day
1	19 6	29	..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Frank Hill Sr
13. Birthplace N.C.

MOTHER 14. Maiden Name Arlene Leonard
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)

(c) Cemetery or crematory Reedis Baptist Cem
Location Lexington, N.C.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd

19 (a) Oct 17 1948 (Date received by local registrar) (b) Huntington Hillsville, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948, at 4 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948, to 10-16 1948, and that I last saw him alive on 10-16 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Tetralogy of Fallot	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 16, 1948

Major findings of operation:
None

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature D.D. Cooley M.D.
Address The Johns Hopkins Hosp. Date signed Oct 16 '48

VS 150

667704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667704

Registered No. 1112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 28 N Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Udoff

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-6240

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5[illegible]7

8. AGE: Years 61 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Paul Udoff
(b) Address 122 Queen Mary Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

OCT 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helpich M.D. Medical Examiner

Date signed Oct 15 1948

VS 181

667705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667705 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Pimlico Road
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Kahn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Bear
13. Birthplace Russia

MOTHER
14. Maiden Name Dosser
15. Birthplace Russia

16 (a) Informant Ida Kahn
(b) Address 4217 Pimlico Rd

17 (a) Burial (b) Date thereof 10-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) (b) Registrar
(Date rec'd by registrar)

OCT 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-1948 at 1H M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Oct 15 1948 and that I last saw h alive on Oct 12 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension C.V.D.	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris A Jaffe M. D.
Address 118 Bi's Bldg Date signed 10/16/48

2.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

667706 Registered No. 667706

667706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. Lutto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

3 (a) FULL NAME Dora Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses Binger
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Louis Kuberman
(b) Address 847 - to Paca St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place Baltimore Md

(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1948 to Oct 15 1948.
and that I last saw h[illegible] alive on October 15 1948.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Cholangeitis

Due to Common duct obstruction due to cholelithiasis and Cholangeitis

Other Condition: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Kuchan M.D.
Address West Balt Med Date signed Oct 16 Resp. 126, 1948

VS 150

G67707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93)

G67707
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bessie Kamenetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Sol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Stein
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Sol Kamenetz
(b) Address 2304 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Baltimore Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1400 Eutaw St.

19 (a) Oct 17 1948 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1948 at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1948 to 10/14 1948 and that I last saw h alive on 10/14 1948.

Immediate cause of death: Acute pulmonary edema — Duration

Due to Acute Myocardial infarction

Due to Ch myocarditis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. H. Hornstein
Address 104 E. Biddle St Date signed 10/15/48

X 10/15/48

VS 150

G67708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G67708
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB S FRANK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/64

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER
12. Name Simon
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia
15. Birthplace Germany

16 (a) Informant Louis M. Frank
(b) Address 1007 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Fuell Lewis Inc
(b) Address 2600 Eastern Place
Huntington Williams, Md

19 OCT 17 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1948. at 3 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1948. to 10-14 1948.
and that I last saw him alive on 10-14 1948.

Immediate cause of death	Duration
(a) Arteriosclerotic heart failure	
Due to (b) Pulmonary and renal	
Due to (c) Carcinoma, uremia	
Due to (d) Carcinoma of prostate	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas S Weinstein M.D.
Address Sinai Hosp. Baltimore Date signed 10/14 M

VS 150

667709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 667709 Registered No. 93

Type or write with ink. Use black ink. Do not fold. Be sure that the answers are written clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Pembridge Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Pembridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Saul Gardiner - FORMERLY SAMUEL ALSO SAM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) [illegible]

8. AGE: Years	Months	Days	If less than one day: hr	min.
51				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Michael
13. Birthplace Poland

MOTHER
14. Maiden Name Esther
15. Birthplace Poland

16 (a) Informant Ida Gardiner
(b) Address 1009 Pembridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Mount Montefore
Location West Bltvd

18 (a) Funeral director Jack Levin
(b) Address 2100 Eutaw Pl.

19 (a) [illegible] (b) Huntington Williams, Md

OCT 17 1948

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1948, at 12:50 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948, to Oct. 16 1948, and that I last saw h[illegible] alive on Oct. 16 1948.

Immediate cause of death	Duration
Coronary thrombosis	months
Due to Arteriosclerosis heart C-V disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Gardiner M. D.
Address 2212 South Rd Date signed 10/16/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66720 (937)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Riggs Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Gibbs

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Magdalene B. Gibbs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1873

8. AGE: Years 74 | Months 9 | Days 25 | If less than one day: hr. min.

9. Birthplace Port Royal, Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B.& O. R.R.

FATHER
12. Name Charles E. Gibbs
13. Birthplace Port Royal, Va.

MOTHER
14. Maiden Name Mary S. Parr
15. Birthplace Va.

16 (a) Informant Magdalene L. Gibbs
(b) Address 2922 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 220 W. Lexington St. Baltimore, Md.

OCT 17 1948 (Date received) Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Oct. 14, 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Oct 14 1948 and that I last saw h[illegible] alive on Oct 14 1948.

Immediate cause of death Myocardial degeneration + insufficiency with Congestive failure

Due to Arteriosclerotic type heart disease with coronar

Due to hypertrophy and left ventricular

Other Conditions Angina Pectoris

(Include pregnancy within 3 months of death)

Duration: 3 months — several years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.

Address 2901 Edmondson Ave. Date signed Oct 16 '48

VS 150

G67711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 S Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Borzuchowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Klementyna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12/1869

8. AGE: Years 79 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Frank Borzuchowski

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Sophie Szylanski

(b) Address 219 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Ozarowski

(b) Address 1930 Eastern Ave Huntington Woodlawn, Md.

OCT 17 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Oct. 13 1948 and that I last saw him alive on Oct. 13, 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 10/11/48

Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE ???

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Krupa M. D.

Address 219 S. Chester St Date signed 10/15/48

VS 150

G67712 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 461217

461217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town BAY VILLAGE, (If outside city or town limits, write RURAL and give town)
(d) Street No. 25720 LAKE, ROAD, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Ray Frazier, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-17-31

8. AGE: Years	Months	Days	If less than one day
17	8	29	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Edwin R. Frazier
13. Birthplace Indiana

MOTHER 14. Maiden Name Cora Wickam
15. Birthplace Ohio

16 (a) Informant
(b) Address JONES HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 18 1948 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Green Mount Cem.
Location Balto, Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address York Rd. & Rossiter Ave

19 (a) OCT 17 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948, at 1 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to Oct 16 1948 and that I last saw him alive on Oct 16 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Streptococcic Throat Infection	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 9, 1948

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature D.D. Cooley
Address The Johns Hopkins Hospital Date signed Oct 16 '48

VS 150

667713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Webster Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Olevia Nelson

3 (b) If veteran, name war: None

3 (d) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ferdinand G. Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9th. 1871

8. AGE: Years 77 Months 6 Days 6 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John T. Baldwin
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ann Byran
15. Birthplace Maryland

16 (a) Informant Mrs. Estella Wilson
(b) Address 1501 Webster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 1512 Hollins St.

19 (a) Date received OCT 19 1948 Huntington Williams, M.D. (Registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 7:20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/31/48 to 10/15/48 and that I last saw him alive on 10/14/48

	Duration
Immediate cause of death: Pulmonary Edema	5 days
due to Cardiac Decompensation	2½ mo
Due to Arteriosclerotic Cardio-Vascular Disease	10 yrs.
Due to	
Other Conditions Fracture Neck of Rt. Femur	2½ mo.

(Include pregnancy within 3 months of death)

Date of operation 7/30/48 & 8/2/48

Major findings of operation: Transverse Fracture Neck of Rt. Femur

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Stumpassed
(a) Accident, suicide, or homicide Accident out & fell.
(b) Date of occurrence 7/30/48 at 8 P. M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fall after fainting

23. Signature Edward L. Russell M. D.
Address 1213 Light St. Date signed 10/15/48

Earl L. Rogers M.D.

667714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

667714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Cookie st
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Cookie st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Kunkoski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Helen Kunkoski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1883

8. AGE: Years	Months	Days	If less than one day
65	-	25	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Kunkoski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs. Helen Kunkoski
(b) Address 1205 Cookie st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John J. Weber
(b) Address 401 S. Chester Street

19 OCT 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 130

20. DATE OF DEATH Oct 15 1948, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 12 1948 to OCT. 15 1948, and that I last saw him alive on OCT. 15 1948.

Immediate cause of death CARCINOMA OF STOMACH — Duration 2/28/46

Due to

Due to

Other Conditions CARDIO-VASCULAR RENAL DISEASE 9/12/48
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth F. Orenga M.D.
Address 209 N. Gilmor Str Date signed 10/16/48

VS 3

G67715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

G67715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Anuszewski (Anderson)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Joseph Anuszewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1899

8. AGE: Years	Months	Days	If less than one day
49	6	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Byer
13. Birthplace Poland

MOTHER
14. Maiden Name Lena Pawlicki
15. Birthplace Poland

16 (a) Informant Joseph Anuszewski
(b) Address 515 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John A. Weber
(b) Address 401 S. Chester St

19 (a) OCT 17 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION 1030

20. DATE OF DEATH Oct 14 1948. at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948. to Oct 16 1948. and that I last saw her alive on Oct 16 1948.

Immediate cause of death
Hypostatic Pneumonia
Myocardial degeneration
Due to Cerebral Thrombosis

Duration
Hypo 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Leahy M. D.
Address 4324 Pasteur Pk. Date signed 10/16/48

VS 8

MHSC - 4-P-42 1948
G67716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 16aa

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Cayson Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6509 Old Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Louise Hartke

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/48.

8. AGE: Years	Months	Days	If less than one day: hr.	min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James V. Hartke.
13. Birthplace Elkridge, Md.

MOTHER
14. Maiden Name Ethel M. Ohler
15. Birthplace Halethorpe, Md.

16 (a) Informant Mrs. James V. Hartke.
(b) Address 6509 Old Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory St. Augustines Cem.
Location Elkridge, Md.

18 (a) Funeral director Chas. Bowers & Son
(b) Address 601-03 E. Baltimore St.

OCT 19 1948 (a) (Date filed by registrar) (b) Huntington Williamson, M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1948. to 10/16 1948. and that I last saw her alive on 10/16 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: —

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Thurston Williamson M. D.
Address 601 Bon Secours Hosp. Date signed 10/17/48

67717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Montmorr Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Montmorr Ct. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Boone Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Addie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1883

8. AGE: Years 65 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Memphis, Tenn. (town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Memphis, Tenn.

MOTHER
14. Maiden Name Addie Taylor
15. Birthplace Memphis, Tenn.

16 (a) Informant Mrs. Addie Boone
(b) Address 1527 Montmorr Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cark Cem.
Location Memphis Tenn.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Rhode Island Ave.

OCT 18 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/48 19 at 1.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948 to 10/16 1948 and that I last saw h[illegible] alive on 10/15 1948

Immediate cause of death: hypertensive cardiovascular disease — Duration: UNK

Due to (uremia)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M. D. M. D.

Address 1800 EAST MADISON ST. BALTIMORE 5, MD. Date signed 10.17.48

VS 158

67718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHIN DOO WING (QUOCK DOO WING)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	Chinese	MARRIED

6 (b) Name of husband or wife Lucy Quock
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Abt. Mar. 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	7			

9. Birthplace China (Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace China

MOTHER
14. Maiden Name Unknown
15. Birthplace China

16 (a) Informant Kellow Quock (son)
(b) Address 542 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Ming Yung Cem
Location San Mateo Co. Calif.

18 (a) Funeral director Wm Cook Inc
(b) Address 1212 St Paul St

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948, at 2.10am

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Chronic myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed October 15, 1948

VS 151

6719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

Registered No. 66719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) ~~Hospital or~~ institution: Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Jeffrey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline A. Emerine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) June 30 1871

8. AGE: Years	Months	Days	If less than one day
77	3	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Emerine

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Margaret Schneider

15. Birthplace Md.

16 (a) Informant Clarence Middleton

(b) Address 2584 Edmondson Ave

17 (a) Balto. (Burial, ~~cremation, or removal~~) (b) Date thereof 10/18/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Md.

Location

18 (a) Funeral director William Cook Inc.

(b) Address 1217 E. Baltimore St.

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 14-Oct-1947 to 15-Oct-1948 and that I last saw h.er alive on 15-Oct 1948.

Immediate cause of death Cerebral Embolism — Duration 3 days

Due to Arteriosclerotic Cardio Vascular Renal Disease — Oct-47

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Chas W. Edmunds

Address 2746 Alameda Date signed 16-Oct-48 M D

VS 150

57720

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 16720

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs, 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY DOLORES SEEBACH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1933

8. AGE: Years	Months	Days	If less than one day: hr.	min.
15	3 4	7		

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Harry Seebach.
13. Birthplace Balto

MOTHER
14. Maiden Name Mary V. Schmeckes
15. Birthplace Balto

16 (a) Informant Mrs M. D Seebach
(b) Address 2126 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Frederick Rd.

18 (a) Funeral director Wm Cookone
(b) Address 1217 St Paul St

19 (a) 10 18 1948 (Date rec'd by registrar) (b) Funeral Director Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 19 48, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 48 to Oct 17 19 48, and that I last saw h[illegible] alive on Oct 17 19 48

Immediate cause of death
Coronary occlusion
Embolism

Duration 2 Mo.

Due to
Myocardial degeneration

Duration 3 mo.

Due to Phlebitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 9 '48, Aug 24 '48
Major findings of operation: Myomectomy
Carcinoma of cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Oct 19 48

VS 199

X

67721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 67721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ or days) one
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bedford & Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella T. Dorbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	Separated

6 (b) Name of husband Michael John Dorbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 19, 1894

8. AGE: Years	Months	Days	If less than one day
54	1	26	hr. min.

9. Birthplace Camden N.J. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name James G. Hyatt
13. Birthplace Md.

MOTHER
14. Maiden Name Priscilla Pedrick
15. Birthplace N.J.

16 (a) Informant Marie B. Schriefer
(b) Address Bedford & Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 E. Paul St.

19 (a) 10 1948 (Date rec'd by registrar) Per Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 6:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/15 1948 to 10/15 1948, and that I last saw h~~e~~r alive on Oct 15 1948.

Immediate cause of death Peritonitis

Due to ruptured gall bladder

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M.D.
Address Franklin Square Hosp. Date signed 10/15/48

VS 150

1276

5722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 164c

Registered No. 667722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 033 St.
(c) Hospital or institution: UNION MEMORIAL HOSP 27
(d) Length of stay in hospital or inst, (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 HOLLEN RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard E. Walters

3 (b) If veteran, name war WORLD WAR II

3 (c) Social Security Account No. 197-05-5715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 13 1906

8. AGE: Years	Months	Days	If less than one day
42	6	4	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation MACHINE HAND

11. Industry or business BLACK & DECKER

FATHER
12. Name HARRY R. WALTERS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name DAISY SHOPPERT
15. Birthplace W. VIRGINIA

16 (a) Informant: HARRY T. WALTERS
(b) Address SPARKS MD.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/20/48 (month) (day) (year)

(c) Cemetery or crematory CEDAR GROVE
Location MT. CARMEL RD HERFORD MD.

18 (a) Funeral director Wm Oak Inc.
(b) Address 1217 St Paul St.

19 (a) OCT 18 1948 (Date rec'd by registrar) **(b)** Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Oct. 1948 at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ✓, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound (22 rifle) of mouth & brain

Due to

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 17 Oct 48 at 10:20 A. M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Gunshot

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 17 Oct 48

VS 151

X

667723 BC 48 21157 667723
235-231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 84a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles,
(c) City or town Port Tobacco,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "~~Margaret~~" Compton (Harriet Elizabeth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 - 1948

8. AGE: Years	Months	Days	If less than one day
female 0	0	17 hr.	min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Colvin Compton
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wade
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)

(c) Cemetery or crematory
Location La Plata, Md.

18 (a) Funeral director Hunter & Bryan
(b) Address Waldorf, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 17 - 1948 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-17- 1948 and that I last saw her alive on 10-17- 1948.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Congenital anomaly - Mongolism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Corner, Jr. M. D.
Address Johns Hopkins Hospital Date signed 10-17-48

VS 150

161a

667724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 516

667724 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Oakdale Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State "c." (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Oakdale Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Van Vert Klinefelter, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ella Klinefelter
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) December 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	9	28	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Proprietor, printing
11. Industry or business business

FATHER
12. Name Van Vert Klinefelter
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Hooper
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella Klinefelter
(b) Address 206 Oakdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948, to Oct 15 1948, and that I last saw him alive on Oct 15 1948.

Immediate cause of death	Duration
Carcinoma of Prostate	1 year
~~Due to~~ Nephritis, interstitial, toxic	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hulbert F. Fullerton M. D.
Address 6 E. Biddle St. Date signed

VS 150

Please write the cause of death clearly and legibly.

G67725 CERTIFICATE CORRECTED 9-1-50 G67725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

LCH 123591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Mulberry Street 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALEE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/8/23

8. AGE: Years	Months	Days	If less than one day
25	1	5	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Louisa Harry
15. Birthplace N.C.

16 (a) Informant Records of Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williamson
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/48 19 , at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948 to 10-13 1948.
and that I last saw alive on 10-13 1948.

Immediate cause of death Pul embolism ? Duration
Pul tbc

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address Date signed 10-14-48

VS 150

667726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667726 Registered No. 46

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital, Balto
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 E. Federal St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LUVENIA PATCHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William Patcher
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Aug 1, 1890
8. AGE: Years 58. Months 2 Days 8 If less than one day hr. min.
9. Birthplace: Birmingham Alabama (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Marion McGaw
13. Birthplace: Alabama

MOTHER
14. Maiden Name: Patsy Mason
15. Birthplace: Alabama.

16 (a) Informant: Nonsey Dadaw
(b) Address: 937 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: Mrs Kate R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) OCT 8 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 5:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Oct 15 1948 and that I last saw her alive on Oct 15 1948.

	Duration
Immediate cause of death: Post operative shock	8 hrs.
Due to: Rupture of duodenal stump	
Due to: Whipple Procedure	
Other Conditions: Ca head of Pancreas (Include pregnancy within 3 months of death)	?

Date of operation: Oct 13, 1948.
Major findings of operation: Ca head of Pancreas
of autopsy: Confirmatory; adhesions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. M. Emerson M. D.
Address: Mercy Hosp. Date signed 10/15/48.

VS 150

(66727) ✓ (66727)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Harlem Ave
(c) Hospital or institution: .....
16
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Harlem Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Henry Douglas

3 (b) If veteran, name war: | **3 (c) Social Security Account No.** .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1896

8. AGE	Years	Months	Days	If less than one day
	52	7		..... hr. ..... min.

(d) (m)

9. Birthplace Calvert County, Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Lemuel Douglas
13. Birthplace Calvert County, Maryland

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Calvert County, Maryland

16 (a) Informant: Mrs. Hattie Douglas.
(b) Address 2001 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 19 1948. (month) (day) (year)
(c) Cemetery or crematory Int. Auburn.
Location .....

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Edmondson Ave.

19 (a) [illegible] Washington Blvd (Date rec'd by reg. [illegible]) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V Disease
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature [illegible] M.D. Medical Examiner.
Date signed 10/13/48

VS 131

067728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

067728 Registered No. 37c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Hamburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD BOONE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23, 1904

8. AGE: Years	Months	Days	If less than one day
43	10	21	hr. min.

9. Birthplace Enfield, North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George McWilliams
13. Birthplace Enfield, North Carolina

MOTHER
14. Maiden Name Jessie Boone
15. Birthplace Enfield, North Carolina

16 (a) Informant Jessie Fennell.
(b) Address 313 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 48, at 10:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epidemic Encephalitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 10-15-48

G67729

BALTIMORE CITY HEALTH DEPARTMENT ✓ G67729
Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3214 Elliott St
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stefan Potyraj

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Nora Potyraj
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 11 1886

8. AGE: Years	Months	Days	If less than one day
62	2	5	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Bath Corp Worked

FATHER
12. Name Stefan Potyraj
13. Birthplace Poland

MOTHER
14. Maiden Name Marya Lemiko
15. Birthplace Poland

16 (a) Informant Nora Potyraj
(b) Address 3214 Elliott St.

17 (a) Burial (b) Date thereof Oct 19 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cemetery
Location Dundalk Ave

18 (a) Funeral director John J Duda
(b) Address 2849 Hudson St.

19 (a) OCT 18 1948 (b) Washington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 19 48 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 48 to Oct. 16 19 48, and that I last saw h/m alive on Oct. 14 19 48.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6 hrs.

Due to ARTERIOSCLEROSIS — 2 yrs.

Due to

Other Conditions HEMIPLEGIA — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature Benjamin Schreiber M. D.
Address 121 S. Hanover St Date signed 10/14/48

VS 150

Please write the causes of death clearly and legibly.

Legible approved

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 6627 (30)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 0
(c) Hospital or institution: WEST BALTIMORE GENERAL
(d) Length of stay in hospital or inst. (~~one~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 LAURETTA AVE. (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country ITALY

3 (a) FULL NAME ~~DONATO~~ DONATO MACCIOLA

3 (b) If veteran, name war No

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LEONDINA (X)
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY-4-1882

8. AGE: Years	Months	Days	If less than one day
66	3	13	..... hr. ..... min.

9. Birthplace LARINO ITALY (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business TAILORING

FATHER
12. Name VINCENT MACCIOLA
13. Birthplace LARINO, ITALY

MOTHER
14. Maiden Name CONCETTA CORVENELLA
15. Birthplace LARINO ITALY

16 (a) Informant ROSE M. STRAUSSER
(b) Address 2543 LAURETTA AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location .....

18 (a) Funeral director Raymond C. Sink
(b) Address 3603 Belair Road

19 (a) ..... (Signature by registrar) (b) Registrar's Office

OCT 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1948 to Oct 17 1948. and that I last saw h[illegible] alive on Oct 17 1948.

Immediate cause of death	Duration
Cardio-respiratory arrest	
Due to Cerebral hemorrhage	
Due to Hypertensive cerebral vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Howard Sinkler M. D.
Address West Baltimore Date signed Oct 18 1948

Heil Hoop

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 21

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 Light Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. FISCHBECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Christian W. Fischbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1886

8. AGE: Years	Months	Days	If less than one day
62	0	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Sippel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara E. Fleck
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Avenue

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 19 1948

Wks 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-48 19 , at 7a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 10-14 1948 and that I last saw h[illegible] alive on 10-14 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McGrath
Address 1E. Randall St. Date signed 10/16/48

X

67732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 NORTHEATE RD. (18)
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 N. 13th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN G. JOSBERGER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	Widowed

6 (b) Name of husband or wife Caroline Josberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 17-1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	10	—		

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation (Helper in department store
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant MRS. MARIE NEWELL
(b) Address 1527 NORTHEATE RD.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Welte Funeral Home
Location Philadelphia, Pa.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31.

19 (a) (Date rec'd by registrar) (b) Huntington Pittsburgh, Pa. (Registrar)

VS 1 R 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1948 to 10/17 1948.
and that I last saw him alive on 10/16 1948.

Immediate cause of death	Duration
CEREBRAL THROMBOSIS	6 weeks
Due to CEREBRAL ARTERIOSCLEROSIS	—
Due to	
Other Conditions SENILITY GENERAL ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)	—

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 6330 Belair Rd (6) Date signed 10/17/48

X

67733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Cassidy

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Michael Cassidy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1865

8. AGE: Years: 83 | Months: 8 | Days: 10 | If less than one day: hr. min. 11

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Samuel Gallagher
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Kane
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary McCabe
(b) Address: 815 E Chase St.

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof Oct 20 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Cathedral
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Edgar W. Conklin
(b) Address: 924 E. Eager St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Oct. 1, 1948 and that I last saw her alive on Oct. 16 1948.

Immediate cause of death: Coronary Thrombosis

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Tyson MD M. D.

Address 1623 E. N. Ave. Date signed Oct 19 48

V S 150

G677.34

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G677.34

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Hamilton Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Hamilton Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARA SIMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 76			hr. min.

9. Birthplace Coole, Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Simpson
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Woodsale
15. Birthplace Ireland

16 (a) Informant Miss Annie Simpson
(b) Address 825 Hamilton Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Oct. 15 1948
and that I last saw him alive on Oct. 11 1948

Immediate cause of death. Duration

Due to Cerebral Hemorrhage 6

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Old Age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Myers M. D.
Address 516 Cathedral St. Date signed 10-16-48

V3 150

77.35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ 6677.35 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Chilham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Burke.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	white	widow

6 (b) Name of husband or wife George A. Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 3, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George R. Skillman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Elizabeth Pearce
15. Birthplace Md

16 (a) Informant Mrs. Anna Becker
(b) Address Same.

17 (a) Burial (b) Date thereof 10/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul's Lu. Cem.
Location Arcadia, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1948 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/48 19 to 10/16 19 48
and that I last saw her alive on 10/16 1948.

Immediate cause of death
Resp. failure
Due to Cachexia
Due to Ca. of the Colon
Ruptured Gangrenous
Other Conditions Fecal fistula

(Include pregnancy within 3 months of death)
Date of operation Sept 32, Oct 4.
Major findings of operation: Ca. of the Colon - Tumor
of autopsy Diverticula

Duration 36 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John [illegible]
Address St Agnes Hosp Date signed 10/4/48

VS 150

6777.36

BALTIMORE CITY HEALTH DEPARTMENT ✓ 6627.36

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE L. HERTLEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1863

8. AGE: Years	Months	Days	If less than one day
85	6	2	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation –
11. Industry or business

FATHER
12. Name Gotfred Hertlein
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Sommers
15. Birthplace Germany

16 (a) Informant Miss Phyllis Hertlein
(b) Address 2127 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct. 18, 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1948, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1, 1948 to 10/14 1948
and that I last saw h w alive on 10/14 1948

Immediate cause of death Carcinoma of Breast with Metastasis to Lungs — Duration 1 year

Due to

Due to

Other Conditions Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. W. Carlin M. D.
Address 2145 W Balto St. Date signed 10/15/48

VS 150

X

77737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 92a

Registered No. 6627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Taplow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA LEE WILSUR

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Albert Wilbur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 11, 1877

8. AGE: Years 71 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W. Quarles
13. Birthplace Va.

MOTHER
14. Maiden Name Martha J. Evans
15 Birthplace Va.

16 (a) Informant Mrs. Newton Kidd
(b) Address 122 Taplow Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct. 18, '48 (Date rec'd by registrar) **(b)** Funeral Director, Woodlawn, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 2:25p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948. to Oct 15 1948.
and that I last saw h[illegible] alive on Oct 15 1948.

Immediate cause of death Coronary Thrombosis
Due to Cerebral Hemorrhage
Due to Arteriosclerosis

Duration
1 wk
3 mos.
5 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2308 Garrison Blvd Date signed 10/16/48

VS 150

677.38

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 677.38

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3165 Keswick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3165 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN KILPATRICK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas Henry Kilpatrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 25, 1874

8. AGE: Years	Months	Days	If less than one day
74	2	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Worsdell
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann Dix
15 Birthplace Baltimore

16 (a) Informant Miss Helen E. Kilpatrick
(b) Address 3165 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct. 16 (Date rec'd by registrar) (b) Hurdis M. Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 15 1948, and that I last saw her alive on Oct 15 1948.

Immediate cause of death Arteriosclerotic CVD & Decomp
Due to Ca of Breast

Duration
?
3 mo

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Linnane M. D.
Address 3711 Dallas Rd Date signed 10-16-48

VS 150

6627.59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. 6627.59

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 844 Mangold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODORE J. SCHORBACH

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-09-8871

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	MARRIED

6 (b) Name of husband or wife Margaret A. Schorbach
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 14, 1895

8. AGE: Years	Months	Days	If less than one day
53	3	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foundry Worker
11. Industry or business Piston Ring Co.

FATHER
12. Name "illiam Schorbach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret A. Schorbach
(b) Address 844 Mangold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto md

18 (a) Funeral director J. H. & B. M. Walter
(b) Address 1501 Eutaw St

19 10/18/48 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 9.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquir thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Submersion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following: 21/

(a) Date of injury 10-16-48 at approx. 9.00 a. M.
(b) Where did injury occur? 844 Mangold St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Gas heater on but unlit

23. Signature [signature] M.D. (Medical Examiner)
Date signed October 16, 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Reisterstown Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dora L. Pines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband David Pines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1893

8. AGE: Years 54 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Dress shop - Retail

FATHER
12. Name Isaac Singer
13. Birthplace Unknown

MOTHER
14. Maiden Name ? Silverman
15. Birthplace Unknown

16 (a) Informant Mr. David Pines
(b) Address 2437 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto., Md.

18 (a) Funeral director David Londeree & Son
(b) Address 1902 Eutaw Place

19 (a) 10/19/48 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-1948, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-1948 to 10-17-1948, and that I last saw her alive on 10-17-1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic heart disease	
Due to Coronary occlusion & hypertensive heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Judith Landau M. D.
Address Sinai Hospital Date signed 10-17

VS 150

X

7741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 16777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1552 Carswell Pl
(c) Hospital or institution:
4-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 Carswell Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebhan

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Rebhan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 24 - 1880

8. AGE: Years: 68 | Months: 1 | Days: 20 | If less than one day: min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual Occupation:
11. Industry or business: At Home

FATHER
12. Name: John Stetler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15 Birthplace:

16 (a) Informant: Mary Rebhan
(b) Address: 1552 Carswell Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory: Balto Cem.
Location: North Ave

18 (a) Funeral director: John E Milly Inc
(b) Address: 2435 E Oliver Pl

19 10/18/48 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 14 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1947 to Oct 14 1948 and that I last saw her alive on Oct 14 1948.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Jack T. Singer, M.D.
Address 5062 Roberts Date signed 10 15 48

VS 150

X

667742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667742 462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos. 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) (2)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1421 McCulloh St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith M. Hayson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Spencer M. Hayson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 11, 1881

8. AGE: Years	Months	Days	If less than one day
67	11	4	hr. min.

9. Birthplace ~~Virginia~~ Maryland
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Orlando Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett Ware
15. Birthplace Virginia

16 (a) Informant Hattie Douglas
(b) Address 1000 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs. James C. Hensley
(b) Address 578 W. Fidler St.

19 (a) Oct. 19 (Date rec'd by registrar) (b) Henderson Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1948, to Oct. 15 1948 and that I last saw her alive on Oct. 15 1948

Immediate cause of death Cancer Stomach — Duration 2 mos.

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation 3/15/48

Major findings of operation: Ca Stomach

of autopsy: Ca Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Robert E. Ensor
Address Mercy Hosp. Date signed 10/16/48

VS 150

67743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Foster Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Foster ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Stacharowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0301

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	3	25		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Stacharowski
13. Birthplace Poland

MOTHER
14. Maiden Name Michalena Pilachowski
15. Birthplace Poland.

16 (a) Informant Mrs. Mary Stacharowski
(b) Address 2515 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) OCT 20, 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1948 to Oct. 17 1948, and that I last saw h[illegible] alive on 10/17 1948

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	10/15/48
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE	5/4/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(e) Means of injury

23. Signature Joseph F. Ahearn M. D.
Address 209 [illegible] Date signed 10/18/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G67744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Maderia St.,
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Maderia St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK ADAM HEISE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Heise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1901

8. AGE: Years	Months	Days	If less than one day
47	3	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Rent collector
11. Industry or business

FATHER
12. Name John C. Heise
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Schelpper
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances Heise
(b) Address 222 N. Maderia St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2008 Orleans St.

19 OCT 18 1948 (Date rec'd by registrar) (b) Tennington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1948 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 19 to 10-14- 19 48, and that I last saw h alive on 10-14- 19 48.

Immediate cause of death	Duration
Chronic Myocardial Disease	1 year
Due to Portal Cirrhosis	2 years
Due to Chronic alcoholism	10 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moore, M.D. M. D.
Address 448 N. Eutaw Pl. Date signed 10-15-48

VS 150

27745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

162 B

Registered No. 27745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4901 Hutton Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4901 Hutton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude G. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	11 d	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John H. Gordon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth L. Stinchcomb
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. E. L. Hoddinott
(b) Address 2646 W. North Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) [illegible] (Signature of registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

11.30

20. DATE OF DEATH October 14, 1948 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 10/14 1948, and that I last saw h[illegible] alive on 10/14 1948

Immediate cause of death Cardiac Failure — Duration 2 days

Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Haslam M. D.
Address (44) W. North Ave Date signed 10/15/48

VS 150

Important: Physicians: please write the causes of death clearly and legibly.

67746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. 66776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard J. McGarity

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine S. McGarity
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1905

8. AGE: Years	Months	Days	If less than one day
43	6	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Substitute Mail Carrier
11. Industry or business

FATHER
12. Name Bernard J. McGarity
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret O'Brien
15. Birthplace Md.

16 (a) Informant Mrs. Catherine S. McGarity
(b) Address 2222 Poplar Grove St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (Date rec'd by registrar) Herbert Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1948, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948, to 10-16 1948, and that I last saw him alive on 10-16 1948.

Immediate cause of death Acute Coronary Occlusion — Duration

Due to

Due to

Other Conditions Pre-gloria gastric ulcer (malignancy (?))
(Include pregnancy within 3 months of death)

Date of operation 10-16-48

Major findings of operation: chronic perforated

of autopsy: Same as dx

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Bintzer M.d. M. D.
Address WBGH Date signed 10-16-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Ferndale Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57-3-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Ferndale Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer W. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma M. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1891

8. AGE: Years 57 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrical Contractor

11. Industry or business

FATHER
12. Name Edward Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Emma M. Thomas
(b) Address 3714 Ferndale Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 10/18/48 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) Oct. 16th 1948, at 7:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.

Date signed Oct. 16, 1948

VS 151

667748 3C-48-22605

667748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Marx Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Boy McCrory "B"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct 17 1948

8. AGE: Years | Months | Days | If less than one day 7 hr. 43 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Donald Joseph McCrory
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine Eliz. Sheehy
15. Birthplace Baltimore Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mary Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Conklin
(b) Address 924 E. Lexington St. Baltimore, Md.

19 (a) OCT 18 1948 (Date received by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948, at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1948 to Oct 17 1948 and that I last saw h[illegible] alive on Oct 17 1948.

Immediate cause of death — **Duration**

Prematurity

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Eugene O. Goldstein
Address J. H. Hospital Date signed 10/17 M. D.

VS 150

667749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

667749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave.
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Whole life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Auchentoroly Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary A. Costello

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-78

8. AGE: Years	Months	Days	If less than one day
70	0	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name John F. Costello
13. Birthplace County Kerry, Ireland

MOTHER
14. Maiden Name Mary Jane McGovern
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella Browning
(b) Address 4900 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 900-03 Hollins St.

19 (a) OCT 18 1948 (Entered by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16th 1948, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948 to 10-16 1948, and that I last saw her alive on 10-15 1948.

Immediate cause of death	Duration
Cardiac Rafe Failure	
Due to Hypertension Arteriosclerosis Cardio-Vasc. Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Chas. L. Carr Jr. M.D.
Address St Agnes Hosp - Date signed 10/16/48

VS 150

667750 TONSTALL Johnson ✓ 667750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667750

1219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Boone St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Gunstall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Mary Gunstall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1881

8. AGE: Years	Months	Days	If less than one day
67	5	-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Benjamin Gunstall
13. Birthplace Va

MOTHER
14. Maiden Name Mary P.
15. Birthplace Va

16 (a) Informant Drucella Gunstall
(b) Address 2615 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 19 48 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St. Baltimore, Md.

19 (a) OCT 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 11 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 15 1948, and that I last saw h alive on Oct 15 1948

Immediate cause of death	Duration
Cardio. Renal Disease	14 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A Johnson M.D.
Address 2029 Eutaw Pl Date signed Oct 19 1948

V S 150

Accident room

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(92)

Registered No. 66751

66751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 E. Monument st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Barney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar-4-1900

8. AGE: Years 48 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Randolph Blackwell

13. Birthplace md

MOTHER 14. Maiden Name Martha Jackson

15. Birthplace md

16 (a) Informant Thelma Barney

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Rest

Location Towson md

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) OCT 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

05p

20. DATE OF DEATH Oct. 14 1948, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to 19; and that I last saw h alive on 19

Immediate cause of death: Cardiac Failure — Duration

Due to: Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation

of autopsy:

CERTIFICATION APPROVED BY PHYSICIAN

J. G. Merrill M.D.

CHIEF OR ASST. MEDICAL EXAMINER

Underline the cause to which death should be charged statistically.

25

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thomas J. P. Johns

Address Johns Hopkins Hosp (Date signed) 10/15/48

VS 150 To be approved by Medical Ex

G67752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 18 days
(e) Length of stay in Baltimore (yrs., mos., or days): 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3908 N. 5th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: ROGER CHARLES COOPER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Va. Cooper
6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 21, 1912

8. AGE: Years: 36 | Months: 4 | Days: 26 | If less than one day: hr. min.

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Adm. Asst.
11. Industry or business: U.S. Public Health Service

FATHER
12. Name: Charles Cooper
13. Birthplace: NJ

MOTHER
14. Maiden Name: May Agnes Baker
15 Birthplace: NJ

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 18 1948 (month) (day) (year)
(c) Cemetery or crematory:
Location: Arlington, Va.

18 (a) Funeral director: Harry Fultz & Co.
(b) Address: 401 Edmondson Ave

19 OCT 18 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1948, to Oct. 17 1948, and that I last saw him alive on Oct. 17 1948.

Immediate cause of death: Leukemia, myelogenous, chronic — Duration: 1 yr.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 10/18/48 M.D.

V S 130

6677-87 9989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. 6677-53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL, and give town)
(d) Street No. 625 S. Ponca Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marko Benkovic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 9-25-86

8. AGE: Years: 63 | Months: - | Days: 22 | If less than one day: hr. min.

9. Birthplace: Yugoslavia - (Town, county, and state)

10. Usual Occupation: Crane Operator -

11. Industry or business

FATHER 12. Name: Judge Benkovic -

FATHER 13. Birthplace: Yugoslavia -

MOTHER 14. Maiden Name: Zeleu

MOTHER 15. Birthplace: Yugoslavia

16 (a) Informant: Records -

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)

(c) Cemetery or crematory: Sacred Heart
Location: Cepna Hill Rd

18 (a) Funeral director: Lilly & Zacher
(b) Address: 903 S. Wolfe St.

19 OCT 18 1948 (Date rec'd by registrar) Lemington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 11.05

20. DATE OF DEATH Oct. 17 1948 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct 17 1948 and that I last saw h alive on Oct 17 1948

Immediate cause of death Lymphosarcoma (Duration: 2 yrs)
Metastases to lungs
Due to Some
Due to
Other Conditions pleural effusion (Duration: 5 days)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature H E Beckmann M D
Address Johns Hopkins Hosp (Date signed)

77:54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66777:4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME emc JAMES Edgar ARNOLD

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-7660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Francis Viola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	20	hr. min.

(cjm)

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edgar F. Arnold
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence A. Bourek
15. Birthplace Maryland

16 (a) Informant Martha Brammer
(b) Address 5604 Benton Heights Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 18/ 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Frederick Avenue

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street.

19 (a) OCT 18 19[illegible] Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948; at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A S C V D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature E. L. Ryon M.D.
Medical Examiner.

Date signed 10-15-48

VS 181

6677:55

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 6677:55

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Dennison St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 - Madison ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hicks

3 (b) If veteran, name war: | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	widowed

6 (b) Name of husband or wife Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-1889

8. AGE: Years	Months	Days	If less than one day
58	10	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Home maker
11. Industry or business

FATHER
12. Name Mr Jack Bryant
13. Birthplace North Carolina

MOTHER
14. Maiden Name Miss Mary Porter
15. Birthplace North Carolina

16 (a) Informant Mr Thomas Hicks
(b) Address 760 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1948 (Month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Odenton, Md Anne Arundel Co.

18 (a) Funeral director Mrs. George W. Hollans
(b) Address 1631 Druid Hill Ave.

19 (a) [redacted] (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/1948 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 15 1948 and that I last saw h[illegible] alive on 15 Oct 1948.

Immediate cause of death	Duration
Cardio Vascular Accident	
Due to Diabetes Mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [redacted] Date signed 10-15-48

6677.56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. 6677.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Caldwell St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Hudson St (If rural give location)
(e) Citizen of foreign country? Yes or (No)
If yes, name country

3 (a) FULL NAME Nelson D. Grove

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Rachel C. Grove

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 15 1889

8. AGE: Years	Months	Days	If less than one day
59	4	—	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Clerk, Retired

11. Industry or business Railway Express Agency

FATHER	12. Name ?
	13. Birthplace ?
MOTHER	14. Maiden Name ?
	15. Birthplace ?

16 (a) Informant Charles W. Grove

(b) Address 6324 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 1948 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Windsor Mill Rd.

18 (a) Funeral director Paul C. Ehrenwerth Sr.

(b) Address 3615-17 Wheatsheaf Ave.

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from January 1948 to October 15 1948 and that I last saw him alive on Oct 15 1948

Immediate cause of death Gastric and Esophageal Hemorrhage — Duration

Due to Cirrhosis of Liver

Due to Chronic Congestive Heart Failure

Other Conditions Arteriosclerosis generalized (Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bobby F. Jones M.D.

Address Franklin Square Hosp. Date signed 10/15/48

VS 150

6777.37 122993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

6677.37 Registered No.

1. PLACE OF DEATH:
(a) Baltimnre City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 aa.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County Baltimore,
(c) City or town Raspburg. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7404 Brookwood, Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Bankard Jr. (WILLIAM JOHN BANKARD, JR.)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-09-0323

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laura Bankard

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 7-4-10

8. AGE: Years: 38 | Months: 3 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Standard Oil Company

MOTHER / FATHER

12. Name: William Bankard

13. Birthplace: Md.

14. Maiden Name: Hazel Lee Johnson

15. Birthplace: Maryland

16 (a) Informant: records

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/20/48 (month) (day) (year)

(c) Cemetery or crematory: Moreland Memorial
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 OCT 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 17- 1948 at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-1948. to 10-17-1948. and that I last saw him alive on 10-17-1948.

Immediate cause of death Hepatic coma — Duration

Due to Cholelithiasis & ch. cholecystitis & pancreatic cysts & ~~Duan~~ ch. pancreatitis

Other Conditions Subarachnoid hemorrhage, Diabetes mellitus, pericarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: Fibrinous pericarditis, enlarged liver, scarring of head of pancreas

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [signature]

Address The J.H.H. Date signed 10/20/48

VS 150

126

6677 Sayer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Bayonne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Bayonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Kosker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1879

8. AGE: Years 68 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation salesman

11. Industry or business Levering Coffee Co.

FATHER
12. Name John Kosker
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Tykal
15. Birthplace ?

16 (a) Informant Mrs. Gertrude Kosker
(b) Address 2910 Bayonne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Hargord Road #14

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17th 1948 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to Oct 17 1948 and that I last saw h[illegible]M alive on Oct 17 1948.

Immediate cause of death: Cerebral Thrombosis — Duration: 6 wks

Due to: Generalized Arteriosclerosis — 5 yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature George Kosker M.D.
Address 4808 Harford Rd. Date signed 10/18/48

VS 150

6772.9

Dr. Bawden
1517 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ 6677.9
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4317 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1865

8. AGE: Years	Months	Days	If less than one day
83	5	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Flora Cook
(b) Address 4317 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 18 1948 (Date rec'd by Registrar) (b) Lentington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 1948, at 12.40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1948 to Oct 16 1948, and that I last saw her alive on Oct 15 1948

Immediate cause of death	Duration
Myocardial insufficiency	6 hrs
Due to Coronary thrombosis	3 days
Due to Coronary sclerosis	
Other Conditions General arteriosclerosis. Diabetes. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 151 [illegible] Date signed 10/17/48

94a

G67760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G67760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Mulberry Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: ERNEST HENRY GILSTER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-09-9277

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna M. E.

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 9, 1884

8. AGE: Years: 64 Months: 5 Days: 6 If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Baker

11. Industry or business: Anton Hazel Bakery

FATHER
12. Name: Henry Gilster
13. Birthplace: Germany

MOTHER
14. Maiden Name: Wilhelmina Meyer
15. Birthplace: Germany

16 (a) Informant: Mrs. Edna M. E. Gilster
(b) Address: 1925 W. Mulberry Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 19-48 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE, 17

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 4:05 PM

21. I certify that I took charge of the remains described above, held an Insp & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rys M.D. (Medical Examiner)
Date signed 10-16-48

VS 151

67701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL, and give town)
(d) Street No. 107 4th Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BLAINE ENGLAR

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7813

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Clara E.

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 19, 1882

8. AGE: Years 66 | Months 5 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Carroll County, Md. (Town, county, and state)

10. Usual Occupation Power House Operator

11. Industry or business Davidson Chemical Co.

FATHER
12. Name Benjamin Franklin Englar
13. Birthplace Maryland

MOTHER
14. Maiden Name May E. Perry
15. Birthplace Maryland

16 (a) Informant Mrs. Helen E. Bevans (Daughter)
(b) Address 1016 Andover Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Crematory
Location Baltimore, Maryland

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1948, at 1.50 A.M.

21. I certify that I took charge of the remains described above, held an partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intra-cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following: 9/1
(a) Date of injury 10-15-48 at approx. 8.15 p.M.
(b) Where did injury occur? 1016 Andover Road
(c) Did injury occur at home, on farm, industrial place, in public place? friend's Home While at work? no
(d) Means of injury Fell down steps

23. Signature Earl K. Long M.D. Medical Examiner.
Date signed October 18, 1948

X

G677n2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G677n2 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME ELLA ROSE MOELTER

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F | **5. Color or race** W. | **6 (a) Single, married, widowed, or divorced** Married.

6 (b) Name of husband or wife Martin Moelter **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr) Feb. 10, 1883

8. AGE: Years 65 | Months 8 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Phillip McAleer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Kelleher
15. Birthplace Ireland

16 (a) Informant Mr. Martin Moelter (Husband)
(b) Address 1826 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10-20-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 18 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 8:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct 16, 1948, and that I last saw her alive on Oct. 16, 1948.

Immediate cause of death Respiratory Failure — Duration
Due to Cerebral Hemorrhage
Due to Arteriosclerosis and Hypertensive C.V. Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hospital Date signed 10-16-48

VS 150

G677o3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. G677o3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 W. Lanvale St.
(c) Hospital or institution:
11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION LISTON BROWN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas B. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 16, 1883

8. AGE: Years	Months	Days	If less than one day
55	0	0	hr. min.

9. Birthplace Cambridge, Mass.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Edward Liston
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Mary A. Seabury
15. Birthplace Boston, Mass.

16 (a) Informant Mrs. Philander Broscoe
(b) Address 209 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1929 to date 19 .. and that I last saw him alive on Oct 24 1948.

Immediate cause of death Massive Coronary — Duration sudden

Due to Hypertension

Due to Last prescribed for on Oct 11 1948

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Williams M. D.
Address 12 E. Lager Date signed Oct 19 48

VS 193

BC-48-12240

BALTIMORE CITY HEALTH DEPARTMENT

G67704

CERTIFICATE OF DEATH

8 1a

Registered No. 4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 W North Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DAVID FINECEY

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-48

8. AGE: Years 0 | Months 4 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James R. Finecey
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine B. Egan
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address alone

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 17 - 1948, at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13-1948 to 10-17-1948, and that I last saw him alive on 10-17-1948

Immediate cause of death: Respiratory failure

Due to: Pneumococcal meningitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 9 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn R. Judd M.D.
Address Mercy Hospital Date signed 10-17

X

687765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

687765 Registered No. 84485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 53 days
(e) Length of stay in Baltimore (yrs., mos., or days): Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1237 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Joseph Ernest Watts

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No.: 218-22-0293

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Schindhelm Watts

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1878

8. AGE: Years: 69 | Months: 11 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: None (Barber -retired)

11. Industry or business: None (self)

FATHER
12. Name: Thomas Watts
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rebecca Correll
15 Birthplace: Maryland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/20/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 18 19[illegible] (Date rec'd by registrar) (b) Tuntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 19 48, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 19 48 to Oct 16 19 48 and that I last saw h alive on Oct 16 19 48.

Immediate cause of death: Respiratory failure

Due to: Bronchogenic carcinoma with

Due to: atelectasis and emphysema

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: Bronchogenic carcinoma

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. Watts Jr. M. D.
Address: V.S.M.H. Balto Date signed 10/16/48

V S 150

67706 ✓ 67706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164E

Registered No. ....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 25-
(e) Length of stay in Baltimore (yrs., mos., or days): .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: .....
(c) City or town: Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3427 Sunlea Court (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: .....

3 (a) FULL NAME: GEORGE C. HUNSUCKER

3 (b) If veteran, name war: .....
3 (c) Social Security Account No.: .....

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth
6 (c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): 12-17-17

8. AGE: Years: 30 | Months: 10 | Days: 0 | If less than one day: ..... hr. ..... min.

9. Birthplace: Robbins N. Carolina (Town, county, and state)
10. Usual Occupation: Burner
11. Industry or business: Beth. Steel

FATHER
12. Name: George C. Hunsucker
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Katie Short
15. Birth place: N. C.

16 (a) Informant: Ruth Hunsucker
(b) Address: 3427 Sunlea Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 10/19/48 (month) (day) (year)
(c) Cemetery or crematory: ROBBINS
Location: ROBBINS N. CAROLINA.

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 St Paul St.

19 OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: October 17, 1948, at 10:30 M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull & Internal hemorrhage

Due to: .....

Other Conditions: .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 10-16-48 at Approx. 4:55 P. M.
(b) Where did injury occur? Brager-Eisenberg's Dept. Store
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work?) No
(d) Means of injury: Jumped from second fl. window

23. Signature: Earl L. Kay M.D. (Medical Examiner)
Date signed: .....

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. 66777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLEN FRANK BAMBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1881

8. AGE: Years	Months	Days	If less than one day
67	6	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Westendorf Mfg. Co.

FATHER
12. Name Joseph W. Bamberger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia C. Poole
15. Birthplace Baltimore, Md.

16 (a) Informant John P. Bamberger
(b) Address 405 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 19 48, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inc. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 18/48 From 7:30 A.M. to approx. 12 noon P.M.
(b) Where did injury occur? 405 E. Preston St. Cellar
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung self with necktie

23. Signature John R. Davis, Medical Examiner, M.D.
Date signed 10/18/48

VS 151

6677 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 6677 8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 W. Cross St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Becker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-3102

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary E. Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 11 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	11	6		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Truck Driver
11. Industry or business Barton, Duer & Koch

FATHER
12. Name Becker
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Marie Talbott
(b) Address 17 W. Cross St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 19 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948, at 7 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15 1948 to Oct 17 1948 and that I last saw him alive on Oct 17 1948

Immediate cause of death Chronic Myocarditis (non Rheumatic) (with Edema) — Duration 10 yrs.
Due to
Due to
Other Conditions Chronic nephritis.
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature James E Peterman M.D.
Address 1206 Hanover St Date signed 10/18/48

VS 150

92 D

Ward 9 Asst. 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

Registered No. 6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Aisquith Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter M. Cutler

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frank A.

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) 11-11-76

8. AGE: Years 71 | Months 11 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace R. I. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wellcome Foy
13. Birthplace [illegible]

MOTHER
14. Maiden Name ? Longfellow
15. Birthplace ? R. I.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) ~~Cemetery~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St.

19 (a) 10 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1948 at 6.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948 to 10-15 1948 and that I last saw her alive on 10-15 1948

Immediate cause of death: Bronchopneumonia — Duration: Days.

Due to Chronic Pulmonary Disease & Pulm Emphysema — years.

Due to — years.

Other Conditions Arteriosclerotic Hd. Disease — years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, Myocardial Scarring

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Izzo M. D.
Address The Johns Hopkins Hosp. Date signed 10-16-48

VS 199

107

6770 Brady 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

135a

Registered No. 6770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Kensington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Francis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Josephine Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-99

8. AGE: Years	Months	Days	If less than one day
49	4	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name George Francis
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Evatt
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Harmony Cem.
Location: Wash. D. C.

18 (a) Funeral director Mrs Samuel T. Hensley
(b) Address 578 W. Biddle Street

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 7 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-1 1948, to 10-17 1948, and that I last saw him alive on 10-17 1948

Immediate cause of death pulmonary embolism — Duration 1 min

Due to

Due to

Other Conditions hydronephrosis — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation 10-15-48

Major findings of operation: resection neck obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Beckmann, M.D.
Address Johns Hopkins Hosp
Date signed 10/18/48

VS 150

67771

BALTIMORE CITY HEALTH DEPARTMENT ✓ 667771

Registered No.

BC- 48-24413 CERTIFICATE OF DEATH 15TH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: So. Balt. Gen. Hosp. 21-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town S.B.G.H. Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1116 Carroll
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Albert Elliott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/10/48

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name George Elliott

13. Birthplace —

MOTHER 14. Maiden Name Eva Jemick

15. Birthplace Balt. Md.

16 (a) Informant Eva Jemick

(b) Address Balt. Md. 1116 Carroll

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 1948 (month) (day) (year)

(c) Cemetery or crematory The First German United Evangelical Church Cem

Location 6-10 E. Monument Sts

18 (a) Funeral director Joseph Rauschkolb Jr

(b) Address 604 Washington Blvd

19 (a) OCT 19 1948 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1948, at 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 1948 to 10/18 1948, and that I last saw h[illegible] alive on 10/[illegible] 1948

Immediate cause of death: Uremia — Duration 8 days

Due to Bilateral Pyelonephritis
hydronephrosis

Due to —

Other Conditions —

(Include pregnancy within three months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same as above

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Allan C Prevaskes

Address S. Balto. Gen. Hosp. Date signed 19 Oct 48 M. D.

VS :50

77 72

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Maine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Maine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ellis Terrier

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-3933

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1884

8. AGE: Years	Months	Days	If less than one day
63	9	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation B&O Railroad
11. Industry or business

FATHER
12. Name William R. Packard
13. Birthplace Virginia

MOTHER
14. Maiden Name Leonora Seltzer
15. Birthplace Baltimore Md.

16 (a) Informant Elmer S. Terrier
(b) Address 4206 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armour
(b) Address 3911 Liberty Heights Ave.

OCT 19 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1948, at 1:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 27 1948, to Oct 18 1948, and that I last saw h/m alive on Oct 18 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thos. D. Bubert M. D.
Address 4803 Park Heights Ave. Date signed 10/18/48

VS 150

773

387689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

75C

Registered No. G67773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W. Hoffman, St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Britt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Obadiah Britt

6 (c) If alive, give age ? years

7. Birth date of deceased mo., day, yr: 4-16-86

8. AGE: Years: 62 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Obie Britt
13. Birthplace: Va.

MOTHER
14. Maiden Name: Kate Mosby
15. Birthplace: Va.

JOHNS HOPKINS HOSPITAL

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 20 /48 (month) (day) (year)

(c) Cemetery or crematory
Location: Brookland County Va

18 (a) Funeral director: Mrs. Robt. A. Elliott Daughty
(b) Address: 1129 N. Caroline St

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18- 1948 at 1 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8- 1948 to 10-18- 1948 and that I last saw her alive on 10-18- 1948.

Immediate cause of death: anoxia — Duration

Due to: Hypoplastic anemia

Due to: possible chronic myeloid leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged liver & spleen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: John Oglesby Harvey M.D.
Address: Johns Hopkins Hospital Date 10-19-48

VS 150

737

67714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

Registered No. 67714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1013 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Alston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-99

8. AGE: Years 49 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Edmund Faulkner
13. Birthplace ?

MOTHER 14. Maiden Name Annie Johnson
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs. Robt. A. Elliott Dept
(b) Address 1129 N. Carlton St

OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Oct 16 – 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3-1948 to 10-16-1948 and that I last saw her alive on 10-16-1948

Immediate cause of death Peritonitis and intra abdominal hemorrhage — Duration 2 days

Due to Tuberculous Psoas abscess — 8 months

Due to

Other Conditions Aneurysm aorta ABDOMINAL AORTA — 5

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Peritonitis and psoas abscess

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Marion C. Andrews M.D.
Address Johns Hopkins Hospital Date signed 10-18-48

16

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

127a

Registered No. 66775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glenarm (If outside city or town limits, write RURAL and give town)
(d) Street No. Copper Factory Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Morgan

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Sarah Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-?-65

8. AGE: Years 83 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Jarrate Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Billington
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Gyon
Location Long Green, Md.

18 (a) Funeral director Wm. T. Chatman Jr
(b) Address 1701 Mt. Cullob St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 8:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948, to 10-17 1948, and that I last saw him alive on 10-17 1948.

Immediate cause of death Uremia — Duration 10 days

Due to Benign prostatic hypertrophy — Duration 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. E. Beckmann
Address Johns Hopkins Hosp
Date signed 10/18/48 (M D)

77776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 77776

1202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Union Bridge, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Richard Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Eleanor Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1919

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business

FATHER
12. Name Norman Miller
13. Birthplace Pa

MOTHER
14. Maiden Name Verna Gohn
15. Birthplace Pa

16 (a) Informant Eleanor Wilson
(b) Address Union Bridge, Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10 21 48 (month) (day) (year)
(c) Cemetery or crematory York City
Location York, Pa

18 (a) Funeral director Raymond L Wright
(b) Address Union Bridge, Md

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 19 48, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Oct 18 19 48
and that I last saw h[illegible] alive on Oct 18 19 48

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions Cataract

(Include pregnancy within 3 months of death)

Date of operation Oct 12 1948

Major findings of operation: Incarcerated Cataract

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Frank E Blumbeck M D
Address University Hosp Date signed 10/19/48

67777 BC-48-09007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

✓ 67777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp
(c) Hospital or institution Baltimore Md 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County (Baltimore)
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Mc Kean Ave #17
(If rural, give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Mills

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	baby

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/48

8. AGE: Years — | Months 6 5 | Days 26 | If less than one day hr. min.

9. Birthplace (Balt Md (?)
(Town, county, and state)

10. Usual Occupation baby
11. Industry or business

FATHER 12. Name Ernest Mills
13. Birthplace md

MOTHER 14. Maiden Name Dorothy Yates
15. Birthplace md

16 (a) Informant Dorothy Mills
(b) Address 1009 Mc Kean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. C. County, Md

18 (a) Funeral director Joseph L. Locke
(b) Address 1304 N. Central Ave

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-48 19 . at 6 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948 to 10-18 1948, and that I last saw him alive on 10-18 19.

Immediate cause of death	Duration
(Post oper. shock due to oper. for — Intussusception	
Due to Meckel's diverticulum and an intussusception	
Due to & terminal Gangrene of transverse colon	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation 10-16-48
Major findings of operation: Meckel's diverticulum & intussusception (see above).
of autopsy: Gangrene terminal ileum

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Hunter, M.D.
Address Univ. Hosp. Date signed 10-18-48

VS 150

66778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 66778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 N. Central Ave
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Golden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Married

6 (b) Name of husband or wife Lafeyette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7. 1879

8. AGE: Years	Months	Days	If less than one day
69	1	10	hr. min.

9. Birthplace Clinton, S.C.
(Town, county, and state)
10. Usual Occupation Pensioner
11. Industry or business

FATHER
12. Name Joseph Suber
13. Birthplace S.C.

MOTHER
14. Maiden Name Lavinia Hunter
15. Birthplace S.C.

16 (a) Informant Eula McMorris Clyburn
(b) Address 1414 N. Central Ave.

17 (a) Removal (b) Date thereof 10-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Clinton, S.C.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) OCT 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1948, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1948 to 10/17 1948 and that I last saw h e v alive on 10/6 1948

Immediate cause of death Myocardial Failure — Duration

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Proctor Grant M.D.
Address 601 N. Carrollton Date signed 10/19/48

VS 153

66779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 66779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Ashburton St.
(c) Hospital or institution: 16-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, ~~1907~~ 1908

8. AGE: Years 40 | Months 7 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Station Manager

11. Industry or business American Oil Co.

FATHER
12. Name Thomas L. Dawson
13. Birthplace Md.

MOTHER
14. Maiden Name Frances A. Staylor
15. Birthplace Md.

16 (a) Informant: Mr. William L. Dawson
(b) Address 1027 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 19 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct. 1948 at 11:20 ~~A~~ M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work?
(d) Means of injury

23. Signature Wm. N. Kamman, M.D. Medical Examiner.
Date signed 18 Oct. 48

VS 151

67780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67780

164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD R. HOPKINS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Letitia Hopkins

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1929

8. AGE: Years: 19 | Months: 6 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Camac Trainer

11. Industry or business:

FATHER
12. Name: Russell Hopkins
13. Birthplace: Va.

MOTHER
14. Maiden Name: Elizabeth Ziegler
15. Birthplace: Balto.

16 (a) Informant: Mrs. Elizabeth Altvater
(b) Address: 1721 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)

(c) Cemetery or crematory: Meadowridge
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 1:45P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 17/48 at 11:15 A.M. A.M.
(b) Where did injury occur? 400 ft. behind the Laurel Park Grill
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place (While at work?) No
(d) Means of injury Firearms

23. Signature Earl L. Royston M.D.
Medical Examiner
Date signed 10/18/48

VS 151

67781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G67781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Menlo Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Menlo Drive. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SOLOMON SENKER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5972

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah W. Senker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1875.

8. AGE: Years	Months	Days	If less than one day
72	11	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Samuel Senker,
13. Birthplace Austria.

MOTHER
14. Maiden Name Babette Greenhood,
15. Birthplace Germany.

16 (a) Informant Mrs. Sarah W. Senker,
(b) Address 3706 Menlo Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harid Sonnenschein & Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18th. 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3rd 1948 to 18 Oct 1948, and that I last saw h alive on 18 Oct 1948.

Immediate cause of death	Duration
Coronary thrombosis / Pulmonary edema	4 hours
Due to Hypertension / Atherosclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger Jr. M.D.
Address 1207 Eutaw Place. Date signed 10-20-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67782

67782

181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ARTHUR BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1917

8. AGE: Years 30 | Months 11 | Days 4 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Sparrows Pt.

FATHER
12. Name Earl Brooks
13. Birthplace North Carolina

MOTHER
14. Maiden Name Minnie
15. Birthplace Faulkner, North Carolina

16 (a) Informant: Mrs. Minnie Brooks
(b) Address 1002 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location

18 (a) Funeral director Clough, Wilson
(b) Address 1000 Edmondson ave

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 6:45 PM

21. I certify that I took charge of the remains described above, held an Insp.& Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: L. W. Brown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at 8:20 A. M.
(b) Where did injury occur? Sparrows Point Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Covered with hot flue dust

23. Signature Earl V. Ryan, M.D. Medical Examiner.
Date signed 10-16-48

VS 151

1677783

MH 123367

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1312

Registered No. 1677783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Moseley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Richard Moseley
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 5/9/1898

8. AGE: Years	Months	Days	If less than one day
50	5	7	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Brown
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace N.C.

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Oct. 20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy V. Wilson
(b) Address 1003 Bentley ave

19 (a) OCT 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/48 19 at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1948 to 10-16- 1948 and that I last saw her alive on 10-16- 1948

Immediate cause of death	Duration
Chronic nephritis - uremia	
Due to /	
Due to	
Other Conditions Uremic poisoning	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Nelson M. D.
Address Baltimore City Hospitals Date signed 10-17

VS 150

X

567784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 567784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 N. Whatcoat Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1138 Whatcoat Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Mae Glover Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No. 249-34-4722

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Robert Kelly
6 (c) If alive, give age: 29 years
7. Birth date of deceased (mo., day, yr.): Sept 14th, 1921
8. AGE: Years: 27 Months: 1 Days: 1 If less than one day: hr. min.
9. Birthplace: Ellison S.C. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Gene Glover
13. Birthplace: Ellison S.C.

MOTHER
14. Maiden Name: Bertha Reid
15. Birthplace: Ellison S.C.

16 (a) Informant: Robert Kelly
(b) Address: 1138 Whatcoat Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 19-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Brooklyn, Maryland

18 (a) Funeral director: Joseph L. Russ
(b) Address: 1200 McCulloh Street

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Lavington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948 to 10-15 1948.
and that I last saw h alive on 19

Immediate cause of death: Pulmonary Hemorrhage — Duration
Due to: T. B. advanced Stage
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm R. Boykin M.D.
Address: 1133 Monroe Date signed: Oct 19 1948

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 657785

57785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Bernice ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Bernice ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Virginia Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-1125

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Wm. C. Harris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 19-1912
8. AGE: Years 36 | Months 8 | Days 28 | If less than one day: hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Ladies' Tailoring
11. Industry or business —

FATHER
12. Name Theodore Peters
13. Birthplace Md

MOTHER
14. Maiden Name Julia Pilkerton
15. Birthplace Md

16 (a) Informant Mrs. Julia Peters
(b) Address 22 S. Bernice ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Geo. K. Beyer Jr
(b) Address 1512 Collins St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17- 1948 at 11.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1948 to Oct 17 1948. and that I last saw her alive on Oct 17 1948.

Immediate cause of death: Carcinoma of Colon — Duration 1½ yrs
Due to with metastasis to liver & lung
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Israelson
Address 2158 W. North Ave Date signed 10/19/48

VS 153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109a

Registered No. 657786

657786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARRIE AMELIA LANGLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-3763A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1873

8. AGE: Years	Months	Days	If less than one day
75	---	6 5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Sampson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Peck
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ethel Langley Williams
(b) Address 1241 Irving St. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk. Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 OCT 19 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10.15. 1948, to 10.16 1948, and that I last saw h er alive on 10.16. 1948.

Immediate cause of death Primary atypical pneumonia (viral pneumonia)

Duration 9 days

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M.D.
Address 515 Mulberry St Date signed 10.19.48

VS 150

677787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 677787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT T. CASSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age——— years

7. Birth date of deceased (mo., day, yr.) March 14, 1933

8. AGE: Years 15 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation ———

11. Industry or business

FATHER
12. Name Charles H. Cassell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Frances Penning
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Frances Cassell
(b) Address 524 N. Carey Street

17 (a) Burial (b) Date thereof Oct. 19, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George A. Hallaran
(b) Address 1631 Druid Hill Ave

19 (a) OCT 19 1948 (b) Evelington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

45

20. DATE OF DEATH 10-18- 1948 at 11:A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lymphoblastoma, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.

Date signed 10-18-48

667788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

667788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Carroll
(c) City or town Whitehall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME W. Evans Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Maried

6 (b) Name of husband or wife Elva Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1867

8. AGE: Years	Months	Days	If less than one day
81	1	18	hr. min.

9. Birthplace Whitehall (Town, county, and state) Maryland
10. Usual Occupation Magistrate
11. Industry or business Law

FATHER
12. Name John Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Kirkwood
15. Birthplace Maryland

16 (a) Informant Church record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-48 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Whitehall Rural

18 (a) Funeral director Howard S. Mackelvan
(b) Address Whitehall Md

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at 3.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Oct. 19 1948.
and that I last saw h[illegible] alive on Oct. 19 1948.

Immediate cause of death Anuria — Duration 96 h.

Due to arteriosclerosis, generalized

Due to

Other Conditions Cerebral thrombosis 96 h.
diabetes, ca. lung
(Include pregnancy within 3 months of death)

Date of operation 10/14/48

Major findings of operation: Ca of st.

of autopsy: confirms above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Deaver, M.D.
Address Church Home Date signed 10/19/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66789

66789 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR MORRIS SCHEINDLINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Leona (Mc Kenzie)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1892

8. AGE: Years	Months	Days	If less than one day
56	9	1	hr. min.

9. Birthplace RUMANIA
(Town, county, and state)

10. Usual Occupation MEDICAL DOCTOR

11. Industry or business

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden Name Unk
15. Birthplace

16 (a) Informant Mrs. Leona (Mc Kenzie)
(b) Address 3508 Bank St

17 (a) Burial (b) Date thereof Oct. 19-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Md

18 (a) Funeral director John B Connelly
(b) Address 408 Eastern Ave.

19 (a) OCT 19 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1948 at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1948 to 10/16 1948. and that I last saw h IM alive on 10/16 1948.

Immediate cause of death CACHEXIA & UREMIA — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to

Other Conditions SCHONLEIN's PURPURA
(Include pregnancy within 3 months of death)

Date of operation 10/10/48

Major findings of operation: Generalized Carcinoma

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Lyons M. D.
Address Sinai Hospital Date signed 10/16/48

VS 150

Important: Physicians, please write the causes of death clearly and legibly.

67750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 67750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Belair Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Dieter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 21 - 1868

8. AGE: Years 79 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emanuel Manner
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Kellerman
15. Birthplace Balto

16 (a) Informant Mr Jacob Dieter
(b) Address 2007 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. Herrmann
(b) Address 3901 Kentucky ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17- 1948 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1938 to 10-16-1948 and that I last saw her alive on 10-16-1948

Immediate cause of death	Duration
Acute Myocardial Infarction	1/2 hr.
Due to Hypertension	10 yrs
Due to Cardio-vascular renal Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang
Address 2017 Belair Rd Date signed 10-18-48 M D

VS 150

667791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 152

Registered No. G667791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Str
(c) Hospital or institution: University Hosp. 14 out 15 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? 1882

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace King & Queen's Co. Va. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sister in law Clara Green
(b) Address 516 St Mary's St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 OCT 19 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948, at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-1948 to 10-16-1948 and that I last saw h/m alive on 10-16-1948.

Immediate cause of death	Duration
condro-sarc. of femur	
Due to septicemia	
Due to cellulitis of leg	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H Conner M D M. D.
Address University Hosp Balto, Md Date signed 10-19-48

VS 150

Please write the cause of death clearly and legibly.

G67792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G67792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 North Hilton Street
(c) Hospital or institution: 1 1 1 1 1 1 1 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 North Hilton Street
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY SAWYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife / / / /

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 23-1873

8. AGE: Years 75 | Months 1 | Days 23 | If less than one day ********** hrs. min.

9. Birthplace Harford County, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Sawyer
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Burke
15. Birthplace Maryland

16 (a) Informant Mr. W.A.Williams
(b) Address 626 North Hilton Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 20/48 (month, day, year)
(c) Cemetery or crematory St. Mary's
Location Belair Maryland

18 (a) Funeral director JOHN O. MITCHELL & SONS
(b) Address 1900 EUTAW PLACE...17

19 (a) OCT 19 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 16 / 1948 at 8 A.M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: ~~Natural causes~~ X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 10-16-48

VS 151

667793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667793
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 Ashland Court
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Ashland Court
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma L. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 29, 1863

8. AGE: Years	Months	Days	If less than one day
85	1	19 20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William Price
13. Birthplace

MOTHER
14. Maiden Name Mary Stone
15. Birthplace England

16 (a) Informant Mr. Ross Tarr
(b) Address 1801 Selma Ave. Halethorpe, Md.

17 (a) Burial (b) Date thereof 10/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Cambridge, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 19 1948
Date rec'd by registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1948 12:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 18 48 to Oct. 18 1948, and that I last saw him alive on Oct. 18 1948

Immediate cause of death Pneumonia — Duration 8 hrs.

Due to Myocardial degeneration, 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Johnson M. D.
Address Medical Arts Bldg. Date signed

VS 150

66794 BC= 11-22-55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 16774

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greene & Redwood

(c) Hospital or institution: UH.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Balto. Co. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1 Hoop (If rural give location)

Lot 398 R 19

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Kenneth Bruce Alonzo Murray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 10/13/48

8. AGE: Years | Months | Days 4 | If less than one day: hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER

12. Name Kenneth Bernard Murray

13. Birthplace Philadelphia Pa

MOTHER

14. Maiden Name Margaret Rose King

15. Birthplace Balto, Md

16 (a) Informant Margaret Murray

(b) Address Box 398 R 19, Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md

18 (a) Funeral director Lee G. Kelson

(b) Address 1303 Presstman St

19 (a) OCT 19 1948 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1948 at 7:24 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1948 to 10/17 1948 and that I last saw him alive on 10/17 1948

Immediate cause of death C-R Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Auerbach M. D.

Address UH Date signed 10/18

VS 150

67795

JL - 61573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 67795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 925 S. Fremont Ave.
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME
Peter Farrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1875

8. AGE: Years	Months	Days	If less than one day
73		26	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dowd
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Georgetown Hyde Rd.

18 (a) Funeral director Johns Cowan & Son
(b) Address 901 Hollins St.

OCT 19 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948 at 10 PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 4 1940 to Oct. 16 1948, and that I last saw him alive on Oct. 16 1948.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Hypertension Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Verkes Jr. M.D.
Address Balto City Hosp Date signed 19 Oct 48

VS 350

107

67796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 67796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Woodbine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Woodbine Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Ann Venable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~ Widowed

6 (b) Name of husband or wife Addison A. Venable

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) February 6, 1870

8. AGE: Years 78 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Fairmont, Somerset, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John C. Thomas
13. Birthplace Somerset Md.

MOTHER
14. Maiden Name Emily Jane Revell
15. Birthplace Marion Md.

16 (a) Informant Alice V. Middleton
(b) Address 404 Eutaw Place, Balt. 17 Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 19 48 (month) (day) (year)
(c) Cemetery or crematory Bradshaw Funeral Home
Location Crisfield Maryland

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31 Md.

19 OCT 19 1948 (Date rec'd by registrar) (b) Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 11 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct 18 1948 and that I last saw her alive on Oct 18 1948

Immediate cause of death Congestive Heart Failure — Duration 18 hours

Due to Arteriosclerotic Cardiovascular Disease — 3 years

Due to

Other Conditions Hypertensive Cardiovascular Disease — 2 years
(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation: None done

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Traford Jr. M.D.
Address 3400 Woodbine Ave. - 7 Date signed 10/18/48

VS 150

Physicians: please write the causes of death clearly and legibly. Especially important.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

667797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 667797 Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 E Baltimore St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Rachel B Axelrod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Rev Aaron Axelrod

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day ?
82			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House life

FATHER
12. Name Solomon Resnick
13. Birthplace Russia

MOTHER
14. Maiden Name Pesha
15. Birthplace Russia

16 (a) Informant Rev Aaron Axelrod
(b) Address 1122 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 19 1948 (Registered by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Oct 18 1948 and that I last saw h[illegible] alive on Oct 18 1948

Immediate cause of death General arteriosclerosis
Chronic myocarditis

Duration
5 yrs
5 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Helen L. Solomon
Address 129 S. Broadway Date signed 10/18/48

VS 150

667798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

667798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: University Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYER CHAPNEK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 15, 1892

8. AGE: Years	Months	Days	If less than one day
56	7	3	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Chapanek.
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informan: Rose Chapnik
(b) Address 3714 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E. Baltimore St

18 (a) Funeral director Sol Hyrman Bur
(b) Address 1124-26 N. North ave

19 (a) OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 04 17 1948 to 04 18 1948, and that I last saw h[illegible] alive on 04 18 1948.

Immediate cause of death — **Duration**

Cardiac arrest

Due to coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10, 18, 48

VS 150

G67799

464968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67799 Registered No. 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 E. 41st. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Leon Joseph L. Bozman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Clara Bozman
6 (c) If [illegible], give age 57 years

7. Birth date of deceased (mo., day, yr) [illegible]-25-89

8. AGE: Years	Months	Days	If less than one day
59	6	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation accountant
11. Industry or business

FATHER 12. Name Joseph O. Bozman
13. Birthplace Md.

MOTHER 14. Maiden Name Ida Rogers
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1948 at 7:05 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 10-9-1948 to 10-18-1948. and that I last saw him alive on 10-18-1948.

Immediate cause of death Intestinal obstruction — Duration

Due to carcinomatosis

Due to carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/11/48

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Grayhack M. D.
Address SHH Date signed 10/19/48

John T. Grayhack

667800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 E.Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 E.Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giovanni or John B. Papparotto

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	218-03-4817	Male	White	Widowed

6 (b) Name ~~xxxxxxxx~~ or wife late Perina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1879

8. AGE: Years	Months	Days	If less than one day
69	5	1	hr. min.

9. Birthplace Torsi Italy
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Pietro Papparotto
13. Birthplace Italy

MOTHER
14. Maiden Name Adelaide Sacilletto
15. Birthplace Italy

16 (a) Informant Lena Papparotto (Daughter)
(b) Address 3707 E.Pratt St.

17 (a) Burial (b) Date thereof Oct.20 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave

18 (a) Funeral director Frank Della Rose
(b) Address 322 S.High St.

19 (a) OCT 19 1948 (b) Tinsington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-48 19 . at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 to 10-17-48 19 . and that I last saw h alive on 10-17-48

Immediate cause of death Cerebral Thrombosis — Duration 3 days

Due to Arteriosclerosis

Due to

Other Conditions Gangrene of feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
Address 234 Hamburg St. Date signed 10-19-48

VS 150

667801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

Registered No. 667801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3612 Woodbine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA M. KING

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jack King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct. 4, 1889

8. AGE: Years: 59 | Months: 0 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Laurence
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Sarah Stampe
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Jack King
(b) Address: 3612 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

(a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 17 1948, and that I last saw h alive on Oct 17 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs
Due to: Hypertension Cardio Vascular — 10 yrs
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Thos A Abell M. D.
Address 4509 Liberty Heights Ave Date signed 10-18-48

VS 130

667803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 667803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC TOMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ———

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1902

8. AGE: Years 45 | Months 11 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informan: Ralph Toms
(b) Address 230 N. Durham Street

17 (a) Burial (b) Date thereof October 20, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Maryland

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Avenue

19 (a) OCT 19 1948 (b) Turnington for Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 15, 1948, at 11: A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 10/15/48

G67803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1248

Registered No. 46780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or Institution: St. Joseph's 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Byrd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Margaret Reiner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Herbert F. Reimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1902

8. AGE: Years	Months	Days	If less than one day
46	6	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Hwfe. & Employee
11. Industry or business Court Square Bldg.

FATHER
12. Name Francis C. Hartlove
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary W. Neill
15. Birthplace Balto. Md.

16 (a) Informant Mrs Mary W. Hartlove
(b) Address 1728 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (c) OCT 19 1948 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1948, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28, 1948 to Oct. 18, 1948, and that I last saw her alive on Oct. 18, 1948

Immediate cause of death	Duration
Hanot's Cirrhosis of Liver	
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy E. Reasons Jr. M. D.
Address 1 Bayfield Road. Date signed 10/18/48

VS 150

667804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52B

667804
Registered No.

Please write the entire certificate clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: C Hunch Home and Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4
(e) Length of stay in Baltimore (yrs., ~~mos., days~~) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Stevenson (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jay Monroe Steigelman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Steigelman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-15-07

8. AGE: Years	Months	Days	If less than one day
41	4	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Steigelman, George
13. Birthplace Penna

MOTHER
14. Maiden Name Morrison, Florence
15. Birthplace Penna

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-1948 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Garrison Forest, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948. at 8 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948. to Oct 18 1948. and that I last saw him alive on Oct 17 1948.

Immediate cause of death Carcinoma of bladder & metastases Sigmoid colic Vesical fistula — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Mohlerman M. D.
Address Church Home + Hosp Date signed 18 Oct 48

VS 150

G67805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

469

G67805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave.
(c) Hospital or institution:
St. Agnes Hospital. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State M. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Marys, Roland Park - (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Philip J. Blanc. S.S.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1895

8. AGE: Years	Months	Days	If less than one day
73	—	—	— hr. — min.

9. Birthplace France (Town, county, and state)
10. Usual Occupation Priest.
11. Industry or business

FATHER
12. Name Laurence Blanc
13. Birthplace France

MOTHER
14. Maiden Name Mary P. France
15. Birthplace France

16 (a) Informant Father Leo Bocken -
(b) Address St. Marys Roland Park.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St Charles
Location Lafayette

18 (a) Funeral director Kell-Meade & Co.
(b) Address 805 N. Calvert St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/ 1948, at 1 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 10/18 1948 and that I last saw him alive on 10/17 1948.

Immediate cause of death Acute cardio respiratory failure — Duration

Due to Adeno-Carcinoma of Head of Pancreas with Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/15/48

Major findings of operation: Ca of Head of Pancreas with Metastasis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen H. Padrovic M. D.
Address St. Agnes Hosp. Date signed 10/18/48

VS 150

X

G7806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. (~~Starr~~) Stortz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Gussie (~~Starr~~) Stortz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 30th 1877

8. AGE: Years	Months	Days	If less than one day
71	8	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Policeman
11. Industry or business B & O R.R.

FATHER
12. Name Sidney S. (~~Starr~~) Stortz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Shackelford
15. Birthplace Balt. Md.

16 (a) Informant Gussie (~~Starr~~) (Wife)
(b) Address 2215 W. Lexington St.

17 (a) Burial (b) Date thereof 10/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 20 1948 Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1948 at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1948 to 10/17 1948 and that I last saw him alive on 10/17 1948.

Immediate cause of death Bronchiectasis — Duration 6 mos

Due to

Due to

Other Conditions Cerebral thrombosis 2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 Wilkens Ave. Date signed 10/19/48 M. D.

106 K

VS 150

667807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 W. Melrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 W. Melrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lou Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband William Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 12th 1874

8. AGE: Years 69 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Greenfield, Ind. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Tague
13. Birthplace Ind.

MOTHER
14. Maiden Name Mary A. Frost
15. Birthplace Ind.

16 (a) Informant Mrs. Pannill Martin
(b) Address 4 W. Melrose Ave.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 10/20/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Park
Location Greenfield, Ind.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) OCT 20 1948 (Date rec'd by Registrar) Huntington - Wilmore M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7th 1946, to Oct 17 1948, and that I last saw her alive on 9/23 1948

Immediate cause of death acute Coronary Thrombosis — **Duration** 4 hours

Due to —

Due to /

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work)
(e) Means of injury

23. Signature [signature]
Address 705 Med Arts Date signed M. D. 10/19/48

VS 150

67808 2-46761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. 67808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 E other Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Blum -

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-75

8. AGE: Years	Months	Days	If less than one day
73	7	3	hr. min.

9. Birthplace Md - (Town, county, and state)
10. Usual Occupation Distillery -
11. Industry or business

FATHER
12. Name Joseph Blum -
13. Birthplace Md -

MOTHER
14. Maiden Name Mary Riley
15. Birthplace Md.

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville Bal Co Md

18 (a) Funeral director Wm Cook Inc
(b) Address 21 S Paca St

19 (a) OCT 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948 at 11:30 a M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1948 to Oct. 19 1948 and that I last saw him alive on Oct. 19 1948

Immediate cause of death: Asphyxia — Duration 3 Minutes

Due to Mixo-Fibro Sarcoma of Thyroid Gland — 5 years

Due to — Years

Other Conditions Arteriosclerosis Generalized

Date of operation Oct 2nd 1948

Major findings of operation: Mixo-Fibro-Sarcoma of Thyroid

Report of autopsy: None Allowed.

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods M.D.
Address Johns Hopkins Hosp Date signed Oct 19

VS 183

7809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6578[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Marylaid
(b) Street address Calvert & Baselogo
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Neal, Sr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-9-90

8. AGE: Years	Months	Days	If less than one day
58	2	10	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Garage attendant
11. Industry or business Gasoline sales

FATHER
12. Name John W Neal
13. Birthplace Va.

MOTHER
14. Maiden Name Florence Burnett
15 Birthplace Md

16 (a) Informant Wife
(b) Address same

17 (a) Burial (b) Date thereof Oct 22-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Pott & B. M. Walker
(b) Address Balto & Stricker Sts

19 (a) OCT 20 1948 (b) Huntington, W. Va.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1948, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10-1948 to 10-18 1948, and that I last saw h[illegible] alive on 10-1[illegible] 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Due to Coronary thrombosis	8 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Allyn F. Indot M. D.
Address Mercy Hospital Date signed 10-19-48

VS 150

67810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

67810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 W. Hamburg Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Hamburg Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Campbell

3 (b) If veteran, name war ------- | 3 (c) Social Security Account No. -------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Fred Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/15/1911

8. AGE: Years	Months	Days	If less than one day
36 37	10	1	hr. min.

9. Birthplace Chester S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Thomas Hardy
13. Birthplace S.C.

MOTHER 14. Maiden Name Lizzy Archer
15. Birthplace S.C.

16 (a) Informant Maggie Neely
(b) Address 628 W. Hamburg Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct.
Location A.A.Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 3-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948, to Oct 16 1948, and that I last saw h[illegible] alive on Oct 16 1948.

Immediate cause of death	Duration
Cerebral Hemmitage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius L. White M. D.
Address 1602 Pennsylvania Ave Date signed 10-15-48

VS 150

67811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 67811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE DOBERER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Irene Virginia Doberer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1881

8. AGE: Years 67 | Months 4 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business Own Business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Louise List
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. George L. Doberer
(b) Address 4308 E. Hamilton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18, 1948 at 5 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1948 to Oct. 18, 1948 and that I last saw him alive on Oct. 16, 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Arteriosclerosis, Generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Frank W. Baker Jr.
Address St Joseph's Hospital signed 10-18-48

VS 150

67812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

✓ 67812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 Edgewood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julian H. Jacobs

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 25th 1878

8. AGE: Years	Months	Days	If less than one day
70	6	23	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Grocery Merchant
11. Industry or business Work Self

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Mary R. Jacobs
(b) Address 742 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Mt. Rollins St.

OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1948, at 10 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 18 1948, and that I last saw him alive on Oct 18 1948.

Immediate cause of death Chronic cardio renal disease — Duration 5 yrs.
Due to
Due to
Other Conditions Cirrhosis Liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas T. Kahle, M.D.
Address 1731 Bolton St Date signed 10/19/48

VS 150

121a

667813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

667813 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S. Luzern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Luzern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Kowalewska

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank Kowalewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25/97

8. AGE: Years	Months	Days	If less than one day
51	6 7	23	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Kolebuk
13. Birthplace Poland

MOTHER
14. Maiden Name M. Ochal
15. Birthplace Poland

16 (a) Informant Frank Kowalewski
(b) Address 806 S. Luzern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Interment, Removal, or Cremation

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1948, at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct. 17 1948 and that I last saw h. alive on Oct 17 1948.

Immediate cause of death Cerebral hemorrhage (right hemiplegia)
Due to
Due to
Other Conditions Arteriosclerosis

Duration: one hour

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond R. Nowak
Address 408 S. Patt. Pk. Ave. Date signed 10/19/48 M. D.

VS 150

67814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Cambridge St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walenty Stasiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Stanislawa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2/1875

8. AGE: Years	Months	Days	If less than one day
73.	8	16	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Stasiak
13. Birthplace Poland

MOTHER
14. Maiden Name Bakiona
15. Birthplace Poland

16 (a) Informant Marian Stasiak
(b) Address 344 Susquahanna Ave.

17 (a) Burial (b) Date thereof Oct. 21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 OCT 20 1948 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1948 at 300 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 18 1948.
and that I last saw him alive on Oct 17 1948.

Immediate cause of death
Coronary thrombosis
Cerebral hemorrhage

Duration 5d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Lapsley M. D.
Address 422 Cathedral St. Date signed 10/19/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G-67815

AB-122050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

Registered No. G 67815

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 39 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 610 North Maderia St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Strother

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 19, 1884

8. AGE: Years	Months	Days	If less than one day
64	3	21	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name John Strother

13. Birthplace Va.

MOTHER

14. Maiden Name Mandy ?

15. Birthplace Va.

16 (a) Informant Records - Baltimore City Hosps.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson

(b) Address 1019 Baltimore ave

19 (a) 10/20/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 48 at 10.30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-12 19 48 to 10-14 19 48 and that I last saw him alive on 10-14 19 48.

Immediate cause of death: Aspiration type pneumonia — Duration: days ?

Due to Carcinoma of esophagus with tracheoesophageal fistula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/1/48 & 10/14/48

Major findings of operation: Normal anatomy

of autopsy: carcinoma of esophagus tracheoesophageal fistula aspiration pneumonia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman Earl M.D. M. D.

Address 4940 Eastern Ave Date signed 10/15/48

67815

AB-122050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

Registered No. 67815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 North Maderia St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Strother

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife. ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19- 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57,	3	25	18	41

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name John Strother
13. Birthplace Va.

MOTHER
14. Maiden Name Mandy ?
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof oct. 20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Leroy O. Wilson
(b) Address 1005 Blanty ave

19 OCT 20 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14- 1948 at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1948 to 10-14 1948, and that I last saw him alive on 10-14- 1948

Immediate cause of death	Duration
Respiration type Pneumonia	days
Due to Carcinoma of esophagus with Tracheoesophageal fistula	?
Due to Trachea fistula	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/1942 + 10/14/48
Major findings of operation: Normal anatomy
of autopsy: Carcinoma of esophagus with tracheal fistula and aspiration pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place? in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman J. Cole M.D. M.D.
Address 4940 Eastern Ave Date signed 10/14/48

VS 150 * Stepdaughter-Irene Robinson gave information correct age is 57- X

67816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. 67816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olaf Andersen

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hazel Andersen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1905

8. AGE: Years	Months	Days	If less than one day
43	0	26	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name --- Andersen
13. Birthplace Norway

MOTHER
14. Maiden Name -----
15. Birthplace Norway

16 (a) Informant Mrs. Hazel Andersen
(b) Address 2032 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18/48 19..., at 3:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertrophy and dilatation of heart
Edema of lungs
Fatty degeneration of liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/19/48

VS 151

G678:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G678:7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4009 Evans Chapel Road
(c) Hospital or institution: Union Memorial Hospital (DOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Evans Chapel Rd. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Herbert Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-3720

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife H. Elwood Paxton

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1885

8. AGE: Years 63 | Months 8 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer, Retired

11. Industry or business Roland Park Co.

FATHER
12. Name Richard Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen French
15. Birthplace md.

16 (a) Informant Mrs. Treva D. Martin
(b) Address 1105 Buckley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor Ave.

18 (a) Funeral director Paul E. Bennett
(b) Address 3615-17 Chestnut Ave.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct. 1948; at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 18 Oct. 48

VS 151

67818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 67818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days). 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 W. 34th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Leroy Johnson

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 717-07-7967

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth Virginia Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1903

8. AGE: Years 45 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)

10. Usual Occupation Crew Caller

11. Industry or business Pennsylvania Railroad

FATHER
12. Name Harry M. Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Louella Hedrick
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth V. Johnson
(b) Address 715 W. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1948 (month) (day)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 20 1948 (b) Huntington Williams, M.D.
(Registrar) (Registrar)

MEDICAL CERTIFICATION P.

20. DATE OF DEATH October 18, 1948, at 4:40 M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include conditions within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 10/18/48

VS 151

67819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. 66281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
6 City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W. 34th ST. B
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY DAVIS TALBOTT

3 (b) If veteran, name war Navy
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife MRS Mary L. Talbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 1888

8. AGE: Years	Months	Days	If less than one day
60	4	10	hr. min.

9. Birthplace MARYLAND - West River
(Town, county, and state)
10. Usual Occupation POLICEMAN - Park
11. Industry or business

FATHER
12. Name WILLIAM TALBOTT
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNIE McMAHON
15. Birthplace PA

16 (a) Informant HENRY DAVIS TALBOTT.
(b) Address 927 W. 34th ST. BALT. 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Lentington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 17 1948, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 8 1948, to OCT 17 1948, and that I last saw h[illegible] M alive on OCT 17 1948

Immediate cause of death CORONARY INSUFFICIANCY — Duration

Due to CORONARY ARTERY DISEASE

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William E. Beaven. M. D.
Address Union Mem. Hosp. Date signed 10-17-48

67820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 921

Registration No. 6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. WELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary W. Weller nee Weltner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1867

8. AGE: Years	Months	Days	If less than one day
81	8	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. H. J. Van Voorem
(b) Address 3206 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director [illegible] I. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1948, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948, to 10-18 1948 and that I last saw h[illegible] alive on 10/18 1948

Immediate cause of death Arteriosclerotic Heart Disease — Duration ?

Due to Arteriosclerosis

Due to

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin L. Sunderland, M.D.
Address 1109 St Paul St Date signed 10/19/48

Martin L. Sunderland

VS 150

667821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667821 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 E. 23rd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 E. 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1888

8. AGE: Years: 60 | Months: 4 | Days: 1 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Basil Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Olivia
15. Birthplace Md.

16 (a) Informant Maggie Cole
(b) Address 31 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/48 (month) (day) (year)
(c) Cemetery or crematory St Stephens Am.
Location Essex Md.

18 (a) Funeral director Mrs Dott G. Elliott & Dt
(b) Address 1129 N. Carlin's St.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1948 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 17 1948 and that I last saw h alive on Oct 17 1948.

Immediate cause of death: Uremia Apoplexy — Duration: 4 da.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Rose A Johnson
Address 2029 Guilford Ave Date signed Oct 19, 1948

VS 150

5678.22 LCH-183776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 5678.22

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Burr Way (If rural give location)
(e) Citizen of foreign country? N.A. (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/48

8. AGE: Years	Months	Days	If less than one day
	3	7 9	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Gregory
13. Birthplace ?

MOTHER
14. Maiden Name Jean Cooper
15. Birthplace N.Y.

16 (a) Informant: Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Reed Hill Ave.

19 (a) OCT 20 1948 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/48 19 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/48 19 to 10/17/48 19 and that I last saw him alive on 10/17/48 19

Immediate cause of death: Chronic malnutrition — duration indeterminate - prob. years
Due to: Carcinoma unknown - except poor home care
Due to:
Other Conditions: Enteritis (organism not known yet)
(Include pregnancy within three months)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-19-48

VS 150

154

678823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

678823
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Chatham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Chatham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham J Gillman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Produce Business

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Russia

MOTHER
14. Maiden Name Jessie
15. Birthplace Russia

16 (a) Informant Anna Gillman
(b) Address 3703 Chatham Road

17 (a) Burial (b) Date thereof 10-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharre Tefloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 240 Eutaw Place

19 (a) OCT 20 1948 (b) Lutrington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-1948 at 1:4 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1/1947 to 10/20/1948, and that I last saw h/M alive on 10/20/1948

	Duration
Immediate cause of death: Coronary occlusion	1/2 hr.
Due to: Generalized arteriosclerosis	12 yrs
Due to:	
Other Conditions: Previous coronary occlusion (Include pregnancy within 3 months of death)	10 yrs ago

Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Feldmanft
Address 817 St Paul St Date signed 10/20/48 M.D.

VS 150

X

667824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92

667824
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA B. THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Henry Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1893

8. AGE: Years 55 | Months 5 | Days 13 14 | If less than one day hr. min.

9. Birthplace Moncure, N.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albis Bynum
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Bynum
15. Birthplace N.C.

16 (a) Informant Rosa B. Thompson
(b) Address 937 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director CHAS. R. LAW
(b) Address 802 Madison Avenue-1

OCT 20 1948 (Date rec'd by registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 10-18 1948.
and that I last saw h[illegible] alive on 10-18 1948

Immediate cause of death Cerebral Hemorrhage

Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wadell M. D.
Address 861 Eutaw St Date signed 10-20-48

X

G67825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G67825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gunthrope

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Lula Gunthrope
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25 1897

8. AGE: Years	Months	Days	If less than one day
51	4	22	hr. min.

9. Birthplace Great Falls S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thadeous Gunthrope
13. Birthplace Great Falls S.C.

MOTHER
14. Maiden Name Fannie
15 Birthplace Great Falls S.C.

16 (a) Informant Howard Foster
(b) Address 2130 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) Oct 20 1948 (b) Registrar
Filed (month) (day) (year)
Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 - 1948 at 4 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Oct 10 1948 to Oct 16 1948.
and that I last saw h alive on 19

Immediate cause of death	Duration
Cardio Renal Disease	
Due to	1 Yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Thos. A. Jilson M.D.
Address 2329 Guilford Ave Date signed

VS 153

G67826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. G67826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Giles Road (If rural give location) 2722
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1896

8. AGE: Years 51 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Rock Hill, South Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Woodie McCright
13. Birthplace Rock Hill, South Carolina

MOTHER
14. Maiden Name Jennie
15. Birthplace Rock Hill, South Carolina

16 (a) Informant John S. White (son)
(b) Address 2722 Jiles Road (Cherry Hill)

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** October 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cem.
Location Baltimore city

18 (a) Funeral director Joseph A. Lively
(b) Address 6 E. Mount Royal Ave

19 (a) 10-20-1948 (Local registrar) **(b)** Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 48 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Abdomen

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Reyburn M.D.
Medical Examiner.
Date signed 10-20-48

VS 151

X

G67827

BALTIMORE CITY HEALTH DEPARTMENT ✓ G67827
Registered No.

CERTIFICATE OF DEATH 100 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Port Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Czajkowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Serafina
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1887

8. AGE: Years	Months	Days	If less than one day
61	7	23	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Konstanty Czajkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Adamczyk
15. Birthplace Poland Czyk

16 (a) Informant Mrs Serafina Czajkowski
(b) Address 807 S. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John J. Welbes
(b) Address 401 S. Chester Street

19 (a) OCT 20 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1948, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1948, to 10-18 1948, and that I last saw him alive on 10-18 1948.

Immediate cause of death massive Pulmonary Infarct
Due to thrombophlebitis of leg
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy massive infarct - lung

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Schaal M. D.
Address Sinai Hosp - Balt. Date signed 10-18-48

VS 150

SC-48-2398 ✓ 667828

667828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 667828

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County City

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1076 Granby St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Walter Joseph Brashears ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-3-48

8. AGE: Years	Months	Days	If less than one day
0	0	16	hr. min.

9. Birthplace Balto. Md

(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER

12. Name Joseph Brashears

13. Birthplace Balto Md

MOTHER

14. Maiden Name Betty Bainer

15 Birthplace W. Va.

16 (a) Informant Father

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/1948 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern ave. Road

18 (a) Funeral director Wendell Dippel

(b) Address 312 S. Highland Ave

19 (a) Oct 20 1948 (Date received by Registrar) (b) Huntington Williamsport, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 1948, at 12:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17- 1948, to 10-19- 1948, and that I last saw him alive on 10-19- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Extreme dehydration	2-3 days
Due to Diarrhea, infant of unknown etiology	10 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify (yes) or (no))

(e) Means of injury

23. Signature Allyn P. Jordan M.D.

Address Mercy Hospital Date signed 10-19-48

M D

667829 667829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Wiseman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-07-2792

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret A.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 9-26-89

8. AGE: Years 59 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Shipfitter
11. Industry or business: Beth. Steel Co.

FATHER
12. Name: John Wiseman
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Elizabeth Miller
15. Birthplace: Balto.

16 (a) Informant: Margaret A. Wiseman
(b) Address: 944 N. Castel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4600 Belair Rd.

18 (a) Funeral director: Bigell Bros.
(b) Address: 1800 E. Lombard St

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17-1948 to 10-19-1948, and that I last saw him alive on 10-18-1948

Immediate cause of death: Bronchopneumonia — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Purulent Purulent

of autopsy: Purulent Pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel Brady M. D.
Address: Ind Gen Hosp Date signed 10-19-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67830

ES-123733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13

G6783[illegible]

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

City or town Balto. 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 827 N. Eutaw St.

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Margaret F. Klunk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William ROLAND

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 11-17-09

8. AGE: Years	Months	Days	If less than one day
38	11	2	hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name James Birmingham (D)

13. Birthplace Va.

MOTHER

14. Maiden Name Nancy Wynne (D)

15. Birthplace Va.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) Oct 20 1948 (b) .....

(Date received by Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 19 48, at 3:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-13 19 48, to 10-19 48 and that I last saw her alive on 10-19 19 48

Immediate cause of death

Adv. Advanced pulmonary tuberculosis

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Duration: 3 yrs

Date of operation .....

Major findings of operation: .....

of autopsy: Dr. C.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Margaret A. Morgan M. D.

Address Baltimore City Hosp Date signed 10-21-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

G67831 ✓ G67831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. .....

1. PLACE OF DEATH: Provident Hosp.
(a) Baltimore City, Maryland Balto. Md.
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Archer St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME William E. Pinkney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 13, 1904

8. AGE: Years	Months	Days	If less than one day
43 yr.		4	hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Pinkney
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Snella
15. Birthplace Baltimore, Md.

16 (a) Informant Esther Barnes
(b) Address 618 Archer St.

17 (a) Burial (b) Date thereof Oct 21 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Md

18 (a) Funeral director Isaiah L Brown Sons
(b) Address 1640 Montgomery St

OCT 20 1948 (b) Covington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-48 1948 to 10-17 1948 and that I last saw him alive on 10-17 1948

Immediate cause of death Renal failure

Due to Malignant phase of Chronic glomerulonephritis

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature E. E. Beauchamp M. D.
Address Provident Hosp. Date signed 10/19/48

X

667832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. 667832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Keswick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Keswick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C Frazier

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 - 1873

8. AGE: Years 75 | Months | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Niles
13. Birthplace Conn.

MOTHER
14. Maiden Name unknown
15. Birthplace Md

16 (a) Informant Mrs Catherine L Lang
(b) Address 3218 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Frank H Zeh
(b) Address 814 N 36th St.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

OCT 20 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948 at 7:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 10, 1948 to Oct 19 1948
and that I last saw h alive on Oct 18 1948

	Duration
Immediate cause of death Intracerebral Hemorrhage, Heart Disease	1 day
Due to Hypertension	10 years
Due to Senility	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 848 W 36th St Date signed 10/17/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G678.53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G678.53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Morris St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marissa Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-85

8. AGE: Years 62 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Edwards

13. Birthplace Va

MOTHER 14. Maiden Name Sarah Jones

15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Fort Wayne Ind.

18 (a) Funeral director Charles H. Alexander

(b) Address 1200 Mccullah St. Baltimore, Md

OCT 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Oct 19 1948 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-4-1948 to 10-19-1948 and that I last saw h alive on 10-19-1948

Immediate cause of death Anemia — Duration

Due to Carcinoma of Bladder

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Andrews M. D.

Address Johns Hopkins Hosp Date signed 10-20-48

VS 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 6648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Orkney Rd #12 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country.

3 (a) FULL NAME BABY BOY HALVERSON

3 (b) If veteran, name war: NO —

3 (c) Social Security Account No.: NONE

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT 11, 1948

8. AGE: Years — | Months — | Days 3 | If less than one day hr. min.

9. Birthplace: BALTIMORE, MD (Town, county, and state)

10. Usual Occupation: INFANT

11. Industry or business —

FATHER 12. Name: WILLIAM P. PEARSON
13. Birthplace: MARYLAND

MOTHER 14. Maiden Name: MAXINE HALVERSON
15. Birthplace: WISCONSIN

16 (a) Informant: MAXINE HALVERSON
(b) Address: 512 ORKNEY ROAD BALTIMORE 12, MD

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School OCT 18 1948

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) [signature illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 OCT 1948 at 9:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11 OCT 1948 to 14 OCT 1948, and that I last saw h/M alive on 14 OCT 1948.

	Duration
Immediate cause of death: CARDIO-RESPIRATORY FAILURE	2 HOURS
Due to PREMATURITY (30 WEEKS GESTATION)	3 DAYS
Due to WEIGHT OF BODY - 1050 GMS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: PREMATURITY

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Donald F. England M. D.
Address: MARYLAND GEN. HOSP. Date signed: 15 OCT 48

VS 189

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 46518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution: Hospital for the women of Maryland 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Stoll St (Rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Bloom

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/48

8. AGE: Years | Months | Days 2 | If less than one day hr min.

9. Birthplace Baltimore 17 Maryland. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Howard William Bloom
13. Birthplace Altoona, Pa.

MOTHER
14. Maiden Name Julia McLamb
15. Birthplace Vincent North Carolina

16 (a) Informant Mrs Howard Bloom
(b) Address 939 Stoll St, Brooklyn Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 19 48 (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School
Location OCT 19 1948
Commissioner of Health

18 (a) Funeral director —
(b) Address —

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 2 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 16 1948 to Oct 18 1948, and that I last saw him alive on Oct 18 1948.

Immediate cause of death Cardiac Failure.

Due to Congenital Heart Disease.

Due to Absent Interauricular Septum; Failure of Rotatia Heart and great vessels.

Other conditions

Duration

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vernon C. Kelly, M.D.
Address Woman's Hospital Date signed 10-19-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

78:56 48-22079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

6678.56 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1260 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Wilmering

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/12/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Wilmering
13. Birthplace Germany

MOTHER
14. Maiden Name Ineas Snyder
15. Birthplace Birmingham - Alabama

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School OCT 19 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Livingston Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12/48 19 to 10/13/48 19 ; and that I last saw h M alive on 10/13/48 19

Immediate cause of death (a) Respiratory Failure — Duration
Due to (b) Prematurity
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2428 S. Highland Ave. Date signed 10/13/48

VS 150

6678.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

6678.57

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE O. HEADLEY

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 717-17-7255

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle B. Headley

6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 24, 1897

8. AGE: Years: 51 | Months: 3 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Frederick Co. Va. (Town, county, and state)

10. Usual Occupation: Mechanic

11. Industry or business: Penn. R.R.

FATHER
12. Name: William C. Headley
13. Birthplace: Frederick Co. Va.

MOTHER
14. Maiden Name: Nora Jane Rudolph
15. Birthplace: Shanadoah Co., Va.

16 (a) Informant: Myrtle B. Headley
(b) Address: 1538 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory: Lebnon Cemetery
Location: Lebnon, Va.

18 (a) Funeral director: Frederick A. Cole
(b) Address: 1200 W. Lombard St.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1948, at 6:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage, Spontaneous
Internal Hydrocephalus
Due to: Senile Debility

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl L. Royer M.D. Medical Examiner.
Date signed 10-19-48

VS 151

678838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

678838 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Oxford (If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D # 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emmett James Patrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Emmett James Patrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1898

8. AGE: Years 50 | Months 6 4 | Days 7 2 4 | If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Andy Hayworth
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lilly Simcox
15 Birthplace Tennessee

16 (a) Informant James Patrick
(b) Address Oxford Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ West Nottingham
Location Colora, Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 20 1948, and that I last saw her alive on Oct 20 1948.

	Duration
Immediate cause of death Coronary Occlusion	
Due to Coronary Artery Disease ?	
Due to	
Other Conditions Toxic Thyroidism Menopause. (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mortimer Lee Williams M. D.
Address Union Memorial Hosp. Date signed 10-20-48

94a

VS 193

667839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

Registered No. 667839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: God Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Yoku St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia B. Gilroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or ~~divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 7th 1856

8. AGE: Years	Months	Days	If less than one day
62	0	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name James Gilroy
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Cain
15 Birthplace Md.

16 (a) Informant Mrs. Loretta McGregor
(b) Address 812 E. Preston St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 21 1948 (Burial, cremation, or removal) (b) Turnington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20th 1948 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 18 1948 and that I last saw h[illegible] alive on Oct 18 1948.

Immediate cause of death Acute Myocarditis

Due to Multiple Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Years
Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. J. Corrin M.D.
Address 1012 Edmondson Ave. Date signed 10/20/48

WE 180

G678-0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G678-0 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3436 Elm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3436 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan E. (Parks) Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William (Parks) Parks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3rd 1858

8. AGE: Years 84 | Months 810 | Days 15 | If less than one day hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Ruby.
13. Birthplace Md.

MOTHER
14. Maiden Name Olevia Cox
15. Birthplace Md.

16 (a) Informant Mrs Trout
(b) Address 2423 Maisel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 127 St. Paul St.

19 (a) OCT 21 1948 (Date received by registrar) (b) Huntington Williamson (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20th 1948, at 3 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Oct 20 1948. and that I last saw h[illegible] alive on Oct 19 1948.

Immediate cause of death Cong. Heart Failure — Duration
Arteriosclerosis
C.V. Dis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B. Hassman M. D.
Address 4031 Falls Rd Date signed 10/20/48

VS 199

G6784-1 ES-123838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G6784-1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Hillman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Long

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-18-6437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1883

8. AGE: Years	Months	Days	If less than one day
65	4	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Deceased Long
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Deceased
15. Birthplace Balto. Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITAL S
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 19 48 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 19 48 to 10-20 19 48 and that I last saw h im alive on 10-20 19 48

Immediate cause of death Leanne is Carbonis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vickers M.D.
Address Balto City Hosp. Date signed 20 Oct 48.

VS 150

G6784-2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G6784-2

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William R. Dunphy

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma R. Dunphy
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) May 13th 1876

8. AGE: Years	Months	Days	If less than one day
72	2	5	hr. min.

9. Birthplace Towson Md. (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business Self

FATHER
12. Name Wm S. Dunphy
13. Birthplace Texas Md.

MOTHER
14. Maiden Name Matilda Goodwin
15 Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Emma Dunphy
(b) Address 1216 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 417 St. Paul St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Oct 18 1948 and that I last saw h~~im~~ alive on Oct 17 1948

Immediate cause of death Coma — Duration 24 hours

Due to Cardio Renal — 4 yrs

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Pinegar M.D.
Address 3136 Keswick Rd Date signed Oct 27 1948

VS 150

67843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 67843

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N Carey St.

(c) Hospital or institution: Good Samaritan Nursing Home 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1336 W Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 25 1874

8. AGE:

Years	Months	Days	If less than one day
73	11 10	24 21	hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden Name "

15. Birthplace "

16 (a) Informant Dept Public Welfare Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location Balto.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217-9 St Paul St Huntington Indiana

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948 at 5 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 15 1948 and that I last saw him alive on Oct 13 1948.

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration ?

Due to

Due to

Other Conditions Pros. Pul. Tbc — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?

(e) Means of injury —

23. Signature Carl P Roeding M. D.

Address 1336 W Lombard St Date signed 10/20/48

VS 150

G6784 Dr. Traugott.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. 16784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2313 Greenmount Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE TAWNEY

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Mannion
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret (34
15. Birthplace Ireland

16 (a) Informant Mrs. Emmerick
(b) Address 2313 Greenmount Ave

17 (a) Burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22nd ST.

19 (a) Oct 21 1948 (b) [illegible]
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 19 , at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to Octo 20 1948.
and that I last saw h alive on Octo 19 48

Immediate cause of death Coronary thrombosis.

Due to arteriosclerosis

Due to

Other Conditions arteriosclerotic decomp.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Reuquette M.D.
Address 1623 E. N. Ave Date signed 10/20/48

VS 150

G67845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

Registered No. G67845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4308 Forest Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Bery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Yetta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Percy
13. Birthplace Russia

MOTHER
14. Maiden Name Libby
15. Birthplace Russia

16 (a) Informant Yetta Bery
(b) Address 4308 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1400 Eutaw Place

19 (a) OCT 21 1948 (b) Courtenay Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1948 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Oct 20 1948 and that I last saw h alive on Oct 18 1948

	Duration
Immediate cause of death: Hypernephroma Left Kidney	1 Yrs
Due to: Metastasis to Lung	6 mos
Due to: Pulm. Metastasis	6 mos
Other Conditions: Frequent Bronchial Pneumonia (Include pregnancy within 3 months of death)	6 mos

PHYSICIAN. Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A A Weinstock M. D.
Address 1400 Eutaw Place Date signed Oct 21 48

VS 150

16786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. 16786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Woodington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County C
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Woodington Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Keasmeier Sr

3 (b) If veteran, name war no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna B. Keasmeier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 2 1872

8. AGE: Years	Months	Days	If less than one day
76	6	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Feed Merchant
11. Industry or business

FATHER
12. Name Henry Keasmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Horseman
15. Birthplace Germany

16 (a) Informant Catherine M. Knodt
(b) Address 700 Woodington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn A.A. Co.

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 (a) [illegible] (b) Registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Oct 19 1948.
and that I last saw him alive on Oct 9 1948.

Immediate cause of death Coronary Thrombosis — Duration 6 days

Due to

Due to

Other Conditions Arterio

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest H. Kline M. D.

Address 1731 Poplar Date signed 10/20/48

X

BC 48-20305 G6678:7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G6678:7

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wade ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Carroll Johnson.

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1945

8. AGE: Years	Months	Days	If less than one day: hr	min
3 1/2	7	10		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathan Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Evelyn Gunther
15. Birthplace Md.

16 (a) Informant Mr. Nathan Johnson
(b) Address Wade Ave - Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Oct 23 48

(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd

18 (a) Funeral director Henry A. Wirtz
(b) Address 401 E. Lanvale St

19 (a) Filed (Date received by registrar) OCT 21 1948 (b) Registrar Curtis Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 19 1948, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16/1948 to 10/20/1948 and that I last saw her alive on 10/20 1948

Immediate cause of death CARDIO - RESPIRATORY FAILURE — Duration

Due to ENCEPHALITIS

Due to CEREBRAL EDEMA (MORTIS)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Williams M. D.
Address St. Agnes Hosp. Date signed 10/20/48

VS 150

67848 ES-105645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 67848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Walbrook ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schubert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep. Widowed

6 (b) Name of husband or wife Late Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	2526	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian Schubert
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Schwartz
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave + Gay St.

18 (a) Funeral director Harry H. Kuttle
(b) Address 4101 Edmondson ave

19 (a) [illegible] 21 1948 (b) Huntington Williams, M.D. (Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1948, at 2:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-29 1946 to 10-19 1948, and that I last saw him alive on 10-19 1948

Immediate cause of death Bilat. Far advanced Pulmonary Tuberculosis — Duration 2 Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed Oct. 19-48

VS 150

G67843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67843 Registered No.

160c

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 St. Helena Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Vesley

3 (b) if veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced** Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-15-48

8. AGE: Years — | Months — | Days — | If less than one day 3 hr. 30 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Louis J. Vesley
13. Birthplace Essex, Maryland

MOTHER
14. Maiden Name Dorothy Sheppard
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals-records and Dorothy Vesley
(b) Address 229 St Helena Ave, Md

17 (a) Cremated (Burial, cremation, or removal) **(b) Date thereof** 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 21 (Date rec'd by registrar) **(b)** Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-48 at 12 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-48 to 10-15-48 and that I last saw h[illegible] alive on 10-15-48

Immediate cause of death	Duration
Prematurity	
Due to Premature separation of placenta	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clyde H Kitchens MD
M D

Address 4940 Eastern Ave Date signed 10-15-48

VS 150

667850 BC-48-23 BALTIMORE CITY HEALTH DEPARTMENT 667850

AB-123788

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1511 E. Madison St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Morton-Twin A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16-1948

8. AGE: Years | Months | Days | If less than one day: 5 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Alexander Moore

13. Birthplace Md.

MOTHER

14. Maiden Name Ruth Morton

15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave

18 (a) Funeral director

(b) Address

19 (a) Oct 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October- 16 1948, at 1.03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16- 1948 to 10-16- 1948, and that I last saw him alive on 10-16- 1948.

Immediate cause of death: Prematurity — Duration: 5 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William P. Kean M. D.

Address Baltimore City Hosp. Date signed 10-19-48

VS 159

G678:51

JL - 123798

BC 123490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G678:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 E. Madison Ste
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Morton -"B" - Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Moor
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Morton
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) OCT 21 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 2.20 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948, to Oct. 17 1948. and that I last saw him alive on Oct. 17, 1948

Immediate cause of death Premature

Duration 1 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature William P. Kean M. D.
Address Balto City Hosp Date signed 10-19-48

VS 150

G67852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167

Registered No. G67852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND DORSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE:	Years	Months	Days	If less than one day
	45			hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wesley Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Gross
15. Birthplace Md.

16 (a) Informant Seymore Fischer
(b) Address 532 Burgundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.R.C. Md.

18 (a) Funeral director Sarah L Brownson
(b) Address 1086 Montgomery St

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 7.20p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at ? p. M.
(b) Where did injury occur? 532 Burgundy St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp instrument

23. Signature Emil L Rey M.D.
Medical Examiner.
Date signed October 12, 1948

X

667853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 667853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Brunt Street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife Josephine G. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/25/'74

8. AGE: Years	Months	Days	If less than one day
73	9	23	25 hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elizabeth Jackson
(b) Address 2002 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1946 to Oct 19 1948 and that I last saw h alive on May 10 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	2 yr
Due to Hypertension	2 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey
Address 1928 Penna Ave Date signed 10/20/48 M. D.

VS 153

X

G67854 ✓ 667854

ES- 121536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 667854

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2527 Penn Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gladys Currie (or Gladys Blake)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Clarence Currie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 27, 1905

8. AGE: Years	Months	Days	If less than one day
42	10	21	hr. min.

9. Birthplace Va. (Roanoke) (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER

12. Name W. Gordon Blake

13. Birthplace Va.

MOTHER

14. Maiden Name Pearnie Turner

15. Birthplace Va.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 159

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 10-18- 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1948 to 10-18- 1948, and that I last saw her alive on 10-18-48 1948

Immediate cause of death Respiratory failure

Due to Carcinoma of lung with wide spread metastasis

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-30-48

Major findings of operation: Biopsy - Carcinoma (substantiated by path. report)

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Kinnaley

Address Balto. City Hosp. Date signed 10/21/48 M.D.

E. J. Kinnaley X

667855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 66785

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 1622 Chilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Chilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE BRUNING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Minnie E. Bruning nee Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1871

8. AGE: Years	Months	Days	If less than one day
77	7	26	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Sea Food Dealer

11. Industry or business Self

FATHER
12. Name – Bruning
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Minnie Bruning
(b) Address 1622 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Thurmont, Maryland

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1948, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Oct 17 1948. and that I last saw h[im] alive on Oct 17 1948.

Immediate cause of death Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis J. McGrath
Address 1E. Randall St. Date signed 10/18/48

X

67856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 B

Registered No. 67856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Life
(e) Length of stay in Baltimore (yrs., mos., or days): 85 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1304 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: FRANK JOS. MORRIS

3 (b) If veteran, name war: VA I

3 (c) Social Security Account No.: 220-07-[illegible]886

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Morris

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1891

8. AGE: Years 57 | Months 9 | Days 18 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Plumber

11. Industry or business:

FATHER
12. Name: Joseph Morris
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Hunt
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory: New National Cemetery
Location: Frederick Ave. Baltimore, Md.

18 (a) Funeral director: Lilly & Zeiler, Inc
(b) Address: 403 S. Wolfe St. Baltimore, Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Signature of Registrar: Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19 1948, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 26 1948 to Oct. 19 1948 and that I last saw him alive on Oct. 19 1948.

	Duration
Immediate cause of death: 1- Carcinoma of tongue with regional metastasis	1 yr
Due to: 2- Jaundice due to intrinsic obstruction of	3 mo.
Due to: common bile duct	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 10/20/48 M. D.

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6678:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6678:7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH PARKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife JACOB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1879

8. AGE: Years	Months	Days	If less than one day
68	11	6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Perry Scott
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Galena Md.

16 (a) Informant Alberta Nichols (Niece)
(b) Address 425 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Olivet Cemetery
Location Galena, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Date received by reg. OCT 21 1948 (b) Burlington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th, 1948, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948 to Oct 17 1948 and that I last saw her alive on Oct 17 1948.

Immediate cause of death: Cardiac Decompensation
Duration: 18 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Welch M. D.
Address 513 N. Carrollton Ave Date signed 10-21-48

VS 150

678558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

678558 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square 19
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) /
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 Wilhelm St. (If rural give location)
(e) Citizen of foreign country? (~~Yes or~~ No) If yes, name country

3 (a) FULL NAME Joseph W. Howard

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-07-8715

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary R. Howard

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 18, 1889

8. AGE: Years: 59 | Months: 5 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: U. S. Steel

FATHER
12. Name: George Howard
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Katherine Mitchell
15. Birthplace: Balto. Md.

16 (a) Informant: Mary R. Howard
(b) Address: 1837 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Frederick Ave.

18 (a) Funeral director: Craig Funeral Home
(b) Address: 1216 E. Chase St.

19 (a) Oct 21 1948 (Filed by registrar) (b) (Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from October 15 1948 to Oct. 19 1948, and that I last saw him alive on Oct 19 1948

Immediate cause of death: Cardiac decompensation — Duration

Due to: Arteriosclerotic heart disease

Due to: Arteriosclerosis generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Bobby L. Jones M. D.
Address: Franklin Square Hosp. Date signed: 10/19/48

667859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1178

667859

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 W Lanvale St.
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W Lanvale St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Capt. Christian Olsen

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-5973

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife M. Louise

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1862

8. AGE: Years 86 | Months 10 | Days 0 | If less than one day: hr. ..... min. .....

9. Birthplace Arendal, Norway
(Town, county, and state)

10. Usual Occupation Retired Sea Captain
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace , ,

MOTHER
14. Maiden Name Unknown
15. Birthplace , ,

16 (a) Informant [redacted] Margaret Olsen
(b) Address 306 W Lanvale St

17 (a) Cremation (b) Date thereof 3-22-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Loring Emory
(b) Address 5505 Park Heights Ave

19 (a) 3 1948 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 October 1948 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 to 20 Oct 1948 and that I last saw h (alive on 19 20 Oct 1948.

Immediate cause of death Intestinal hemorrhage Duration 6 months

Due to Duodenal ulcer Indefinite
Papilloma of bladder - retention

Due to

Other Conditions Arteriosclerosis, Cerebral

(Include pregnancy within 3 months of death)

Date of operation 21 Oct. 1948

Major findings of operation:

of autopsy As noted above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Hattenbuger Jr. M. D.
Address 1207 Eutaw Pl. Date signed 20 Oct 48

VS 150

66788-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66788-0

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5227 St. Charles Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5227 St. Charles Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie F. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Samuel Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 6, 1861

8. AGE: Years	Months	Days	If less than one day
79	01	13	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Jacob Buck
13. Birthplace Germany

MOTHER
14. Maiden Name Heinricke Ortwein
15 Birthplace Germany

16 (a) Informant Mrs. Minnie Biggs
(b) Address 5227 St. Charles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Irving Cypress
(b) Address 5005 Park Heights Ave

OCT 21 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1948 at 12:15 P. M

21. I certify that death occurred on the date above stated that I attended deceased from May 1 1947 to Oct 19 1948. and that I last saw her alive on Oct 19 1948.

Immediate cause of death
1) Coronary Thrombosis — Duration 2 wks

Due to

Due to

Other Conditions Hypertension — ?
Heart Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 10/20/48

VS 150

66780-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

66780-1
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
Street address
(c) Hospital or institution: Balto. City Hospital 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa.
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Boston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK G. KLOCEK

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1905

8. AGE: Years [illegible] Months mt - Days 19. If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business

FATHER
12. Name George Klocek
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Feret
15. Birthplace Poland

16 (a) Informant Mr. Barowski
(b) Address 622 S. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1948 (month) (day) (yr.)

(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Maryland

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

[illegible] (Date rec'd by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948, at 8:25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure
Congestion of Both Lungs

Due to

Other Conditions Fatty Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 10-20-48

VS 151

925

6778 52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 6778 52

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for The Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mary Drapczynska

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1859

8. AGE: Years	Months	Days	If less than one day
88	11	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thos Shymanski
13. Birthplace

MOTHER
14. Maiden Name Mary Jamanski
15. Birthplace

16 (a) Informant Sister Sister Superior
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Baltimore

18 (a) Funeral director Rita Windfeld
(b) Address 900 East Biddle St, Baltimore, Md.

19 (a) OCT 21 1948 (b) Emmitsburg Maryland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Oct 20 1948, and that I last saw her alive on Oct 18 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	10 yr
Due to	
Other Conditions Arteriosclerosis	10 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Bell Hall
Address 1631 E North Ave Date signed 10/21/48 M. D.

VS 150

16678-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. 16678-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, give township or district and incorporated town)
(d) Street No. Room 301 Knights of Columbus Cathedral & Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. HOWARD (H.) LENTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Esso Standard Oil Co.

FATHER
12. Name George H. Lentz
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary A. Cullen
15. Birthplace Balto., Md.

16 (a) Informant Frank Lentz
(b) Address 1906 Chelsea Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Balto., Md.

18 (a) Funeral director Sligo Sligo
(b) Address 1426 Light St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948, at 12:56 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest,
Multiple fractures
Hemorrhage due to multiple
incised wounds of wrists

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 20/48 Approx. 12:30 P.M.
(b) Where did injury occur Knights of Columbus Cathedral & Madison Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Sharp instrument - jumped from Building

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10/20/48

VS 151

66788-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66788-4 ✓ Registered No. 928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis T Balcke (LOUIS THEODORE BALCKE)

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1887

8. AGE: Years	Months	Days	If less than one day
60	10	2	hr. min.

9. Birthplace Mt. Pleasant, Iowa (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Bureau Internal Revenue

FATHER
12. Name William F. Balcke
13. Birthplace Vlotho, Germany

MOTHER
14. Maiden Name Louise Hoffman
15. Birthplace Iowa

16 (a) Informant Mrs. Winslow
(b) Address Goucher College Campus, Towson Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory
Location Pekin, Ill.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 21 1948.
and that I last saw him alive on Oct 20 1948.

Immediate cause of death Heart failure — Duration 10 days
Pulmonary edema
Due to Rheumatic cardio vascular disease — 40 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Date of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 100 E 23rd St Date signed 10/20/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 16785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1329 Mt. Royal Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 1329 Mt. Royal Ave.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. LUSTNAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife L. Kathryn Lustnauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supervisor of Education
11. Industry or business State Bd. of Correction

FATHER
12. Name Frederick W. Lustnauer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma G. Schreiner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. L. Kathryn Lustnauer
(b) Address 1329 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 23 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1942 to Oct 20 1948, and that I last saw him alive on Oct 20 1948.

	Duration
Immediate cause of death — Cardiac Dilatation & Pulmonary edema	Sudden attack
Due to Myocardial Insufficiency	Prior to 1942
Due to Hypertension	Prior to 1942
Other Conditions Healed pulmonary tuberculosis, Obesity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 12 E Eager St Balto 2 Date signed 10/21/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

38786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 38786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 Lemont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Doering

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Louisa E. Doering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21st, 1872

8. ACE: Years	Months	Days	If less than one day
76	1	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R.R.

FATHER
12. Name Louis Doering
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Paul M. Doering
(b) Address 32 Fuller Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Lutheran
Location Violetsville

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7101 Belair Rd.

19 Filed [illegible] (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1948, at 4 13 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1948, to 10-20 1948, and that I last saw him alive on 10-20 1948.

Immediate cause of death	Duration
Acute Myocardial Infarction	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 10/20/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0-66787

A MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66787

Registered No. 15c

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1372 N. Caney St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henry C. Taylor

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1906

8. AGE: Years	Months	Days	If less than one day: hr.	min.
42	5	1		

9. Birthplace Ashburn Logan Ky. (Town, county and state)

10. Usual Occupation Ship Fitter

11. Industry or business Sparrows Point

FATHER 12. Name Mathew Taylor

13. Birthplace Dennis, Ky.

MOTHER 14. Maiden Name Lucille Norton

15. Birthplace Dennis Ky.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)

(c) Cemetery or crematory

Location Detroit, Michigan

18 (a) Funeral director Wilson Reese II

(b) Address 108 Washington St. Annapolis Md

19 (a) (Date rec'd by) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948, to 10-19 1948, and that I last saw him alive on 10-19 1948.

Immediate cause of death Respiratory Obstruction — Duration

Due to Peritonsillar abscess and acute mediastinitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY

PHYSICIAN

Date of operation

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William D. Dieterich, M. D.

Address Johns Hopkins Hospital Date signed 10-20-48

Medical Case Returned to Hospital

G67818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67818 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 N. Duncan
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Duncan (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine K. Heyl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Heyl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 24, 1870

8. AGE: Years 78 | Months 5 | Days 24 25 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Mikes
13. Birthplace Czecho-Slovakia

MOTHER
14. Maiden Name Catherine Roman
15. Birthplace Czecho Slovakia

16 (a) Informant Josephine Peroutka
(b) Address 806 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Leach & Son
(b) Address 900 N. Chester St

19 (a) 1948 (Date filed by registrar) (b) Washington, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948 at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-48 19 to 10-19- 1948, and that I last saw h alive on 10-19- 1948

	Duration
Immediate cause of death: Cerebral hemorrhage	5 days
Due to Hypertension	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B. Jones, M.D. M. D.
Address 424 N. Linwood Ave Date signed 10-19-48

VS 150

16787 ✓ X 16787

BALTIMORE CITY HEALTH DEPARTMENT Registered No. 16787

CERTIFICATE OF DEATH 93 D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State WVa (b) County Dodd
(c) City or town Central Sta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Black

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1909

8. AGE: Years	Months	Days	If less than one day
39	4	6	hr. min.

9. Birthplace Central Sta WVa (Town, county, and state)
10. Usual Occupation Office
11. Industry or business

FATHER — 12. Name	John Willis
FATHER — 13. Birthplace	WVa
MOTHER — 14. Maiden Name	Celia Jane Dodson
MOTHER — 15. Birthplace	WVa

16 (a) Informant Mary Brown
(b) Address Ellenboro
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 48 (month) (day) (year)
(c) Cemetery or crematory IOOF
Location Westmoreland WVa
18 (a) Funeral director Geo. M. Justice
(b) Address 811 N. Wolfe St.
19 OCT 22 1948 Huntington, W. Va. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1948, to 10-21 1948, and that I last saw h C B alive on 10-21 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive Cardiovascular - Renal disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp Date signed 10-21-48

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67870

LCH 123863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G678.0

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1828 Mosher Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Doran

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68				

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hugh Hancock

13. Birthplace Texas

MOTHER 14. Maiden Name Susie James

15. Birthplace Texas

16 (a) Informant Balto. City Hosp. records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-48 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Danville Ky.

18 (a) Funeral director Sauers & Heiny,

(b) Address Centreville Md.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/48 to 10/20/48 and that I last saw her alive on 10/20/48

Immediate cause of death: Arteriosclerotic heart disease

Due to: E. cardiac failure

Duration: 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Solen E. Bechtold

Address Balto City Hosp. Date signed 10-21-48 M. D.

X Bechtold

VS 150

G67871

JL - 45125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 D ✓

Registered No. G67871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	7	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Anna Wilson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 6 - 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948 at 6.25 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1939 to Sept. 16 1948, and that I last saw him alive on Sept. 16 1948

Immediate cause of death Carcinoma of Penis

Due to

Due to

Other Conditions Left hemiplegia Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation Sept 9 1948

Major findings of operation: Carcinoma of Penis

of autopsy:

Duration: 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Ford MD
Address 4140 Eastern Ave Date signed 10/19/48

VS 150

G67872

AB-102814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G67872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dillard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Charlotte (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4-1896

8. AGE: Years	Months	Days	If less than one day
52	7	14	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John Dillard (D
13. Birthplace Va.?

MOTHER
14. Maiden Name Mary Desmond (D
15. Birthplace Va.?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 6 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 22 1948 (b) (Local registrar) Hunterstor Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 18- 1948, at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11- 1946 to 9-18- 1948, and that I last saw him alive on 9-18- 1948

Immediate cause of death
Cardiac failure.
Due to Arteriosclerotic Heart Disease.
Due to
Other Conditions Anemia unexplained

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

Duration
2 days
2 yrs
1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Vinkers J.
Address Balto City Hosp Date signed 10 Oct 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 667873

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. 5 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1627 Abbey St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lacy Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: negro

6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 40 | Months | Days | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business University Hosp.

FATHER 12. Name Wm.

13. Birthplace N. Carolina

MOTHER 14. Maiden Name Roundy

15. Birthplace S. Carolina

16 (a) Informant:

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 15 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 22 1948 (Date rec'd by registrar) (b) Entaytor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1948 to Oct. 12 1948 and that I last saw h[illegible] alive on Oct. 12 1948.

	Duration
Immediate cause of death: cardiac failure	
Due to: possible acute myocardial infarction	
Due to: arteriosclerotic heart disease	
Other Conditions: possible pulmonary infarction	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature John White M D

Address University Hosp Date signed 10-12-48

VS 150

G67874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G67874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 George Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME CHARLES CLOCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation "

11. Industry or business "

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant ———
(b) Address ———

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School OCT 1 - 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948, at 12.25 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed SEPT. 20, 1948

VS 151

G67875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G67875
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Briscoe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHELLIE GRIFFEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 13 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948 at 6.15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, or public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 9/29/48

VS 151

G67876

JL- 123472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G67876 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home Address (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Albert Wilspn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. ? ? ?

8. AGE: Years 45 ? | Months | Days | If less than one day: hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Henry Wilson

13. Birthplace Md.

MOTHER 14. Maiden Name Mary ?

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 19 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct. 8 1948, and that I last saw him alive on Oct. 8 1948

	Duration
Immediate cause of death Pulmonary edema and cerebral embolism	1 day
Due to Paroxysmal tachycardia	1 day
Due to Hypertensive Cardiovascular disease	2-3 years
Other Conditions Bronchopneumonia	1 day.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Stutzman M.D.

Address Balto. City Hosp. Date signed 10-8-48

VS 150

G57877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 B

Registered No. G57877

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 66 days

(e) Length of stay in Baltimore (yrs., mos., or days): 66 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Texas (b) County: Galveston

(c) City or town: (If outside city or town limits, write RURAL and give town)

(d) Street No.: 205- 20th St. (If rural give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country:

3 (a) FULL NAME: FRED ALBERT ANDERSEN

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 550-26-1897

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	7	hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Seafarer

FATHER
12. Name: Anders Albertson
13. Birthplace: Norway

MOTHER
14. Maiden Name: Mathilda Albertson
15. Birthplace: Norway

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct-22-48 (month) (day) (year)

(c) Cemetery or crematory: St Peters
Location: Lorman Corner

18 (a) Funeral director: Ray B Wolverton Inc
(b) Address: 403- E-25th St.

19 OCT 22 1948 (Date rec'd by registrar) (by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1948, at 5:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Oct. 18 1948, and that I last saw him alive on Oct. 18 1948.

Immediate cause of death	Duration
1- Carcinoma of tongue with regional metastasis	18 mos.
2- Bronchopneumonia	3-4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address: Clinical Director Date signed: 10/21/48

V S 150

662878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G62878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ft. of William Street
(c) Hospital or institution:

241

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U (b) County
(c) City or town N (If outside city or town limits, write RURAL, and give town)
(d) Street No. K No. Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country W N

3 (a) FULL NAME DANIEL KELLY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace U (Town, county, and state)
10. Usual Occupation N
11. Industry or business K

FATHER
12. Name N
13. Birthplace O W

MOTHER
14. Maiden Name U N
15. Birthplace N K

16 (a) Informant N
(b) Address O

17 (a) (Burial, cremation, or removal) (b) Date thereof N (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 13 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 48 at 7:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 10-2-48 at 6:30 A. M.
(b) Where did injury occur? Found: Ft. of William St
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor, While at work? ?
(d) Means of injury Found drowned

23. Signature M.D.
Medical Examiner.
Date signed 10-2-48

VS 181

Correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

G67879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83

Registered No. G67879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Found: Jones Falls
(c) Hospital or institution:
East & Bank St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State X D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 12th St. N.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY DANFORTH

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1 - 1948
18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 22 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 29,'48 at Approx. 9:30 A.M.
(b) Where did injury occur? Found in Harbor off Pier #6
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Drowning

23. Signature Medical Examiner M.D.
Date signed 8-30-48

VS 151

X

G67880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G67880 Registered No.

1. PLACE OF DEATH: 5440
(a) Baltimore City, Maryland
(b) Street address 4045 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA ALICE CONKLING

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William N. Conkling
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1879

8. AGE: Years 68 | Months 10 | Days 26 | If less than one day — hr. — min.

9. Birthplace Baldwin, Balto. Co., Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George W. Francies
13. Birthplace Baldwin, Md.

MOTHER
14. Maiden Name Fannie Porter
15. Birthplace Baldwin, Md.

16 (a) Informant John Conkling
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove Cem
Location Jacksonville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Transcription by Williams, Mrs Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct 19 1948, and that I last saw her alive on Oct 18 1948.

Immediate cause of death: Hypertension & Arteriosclerosis — Duration 15 yrs.
Due to Chronic myocarditis
Due to
Other Conditions Uremia, Urinary retention
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. V. Harbold M. D.
Address 4706 Harford Road Date signed 10-21-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67881

ES-121736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G67881

Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE
(c) Hospital or institution:
BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Houser St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 15, 1880

8. AGE: Years 68 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jim Locke
13. Birthplace Md.

MOTHER
14. Maiden Name Betty Chew
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W. Fitch Ave

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Burial Permit Issued

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 10-20- 1948 at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 10-20 1948 and that I last saw her alive on 10-20 1948

Immediate cause of death: Pulmonary Embolism

Due to: Post operative

Due to:

Other Conditions: Hypertension, Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 9-21-48

Major findings of operation: Uterine Fibroids

of autopsy:

Duration: Months

PHYSICIAN
Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

667882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 a ✓ Registered No. 667882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 5312 Ethelbert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Ruth Saltstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 25 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Louis Miller
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannie
15. Birthplace: Russia

16 (a) Informant: Murray Saltstein
(b) Address: 5312 Ethelbert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-22-48 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jack Rawdone
(b) Address: 2400 Eutaw Place

19 (a) [illegible] 22 1948 (b) Huntington Woods, Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Oct. 1948, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Anaphylactic Shock

Due to: Intravenous Injection of Sodium Morphate

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: Oct. 21, 1948 Approx. 2:30 P.M.
(b) Where did injury occur? 2519 Eutaw Place
(c) Did injury occur at home, in farm, industrial place, in public place? Dr's office While at work?
(d) Means of injury: Intravenous injection of Sodium Morphate

23. Signature: Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed: 21 Oct. 48

VS 151

Type, typewrite, please write the causes of death clearly and legibly.

G67883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G67883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Edgevale Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~County~~ Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Edgevale Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN ROBEY LENGNICK

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Henry A. Lengnick
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June-16-1874

8. AGE: Years	Months	Days	If less than one day
74	4	4	____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Joseph Henry Marston
13. Birthplace: ? ? U. S. A.

MOTHER
14. Maiden Name: Elizabeth Helen Snyder
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Bessie M. Walker (sister)
(b) Address: 608 Edgevale Road, City #10.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct-23-1948 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Avenue, City #1.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948, at 12 N.

21. I certify that death occurred on the date above stated; that I attended deceased from — 1936 to Oct 20 1948 and that I last saw h e alive on Oct 19 1948.

Immediate cause of death	Duration
Congestive heart failure	July 1948
Due to Arteriosclerotic heart disease	
Due to Arteriosclerosis Symptoms	Since 1936
Other Conditions Hypertension	Since 1926

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed 10/21/48

VS 150

G67884 LCH-123603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

G67884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17 03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 E. Franklin Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?, ? ?

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Wm. Francis A. Hensley
(b) Address 578 W. Biddle St

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/48 19 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8/48 19 to 10/19/48 19, and that I last saw her alive on 10/19/48 19.

Immediate cause of death ? Duration
Poss. coronary occlusion ? Instant
Poss. pul. embolus ?
Due to
Due to
Other Conditions Cachexia, malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No significant

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M J Nelson M. D.
Address Balto City H. Date signed 10-21-48

VS 150

067885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174A

Registered No. 067885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: HOWARD
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Edward Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	(Married)

6 (b) Name of husband or wife Sally Pruitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 28 1897

8. AGE: Years	Months	Days	If less than one day
51	8	19	hr. min.

9. Birthplace Salem North Carolina (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John Pruitt
13. Birthplace Va

MOTHER
14. Maiden Name Patrecia Childress
15. Birthplace Va

16 (a) Informant Pauline F Warner
(b) Address Harmons Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director D C Hyde Johnson
(b) Address Ellicott City Md

19 (a) OCT 22 1948 (b) Torrington Williams, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-48 19 . at 5-04 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 19 to 10-21 19 .
and that I last saw him alive on 10-21-4819

Immediate cause of death Respiratory Paralysis (Central)
due to
Due to Chronic alcoholism
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Hahn M. D.
Address University Hosp Date signed 10-21

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2748 Lively Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Parsons

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-10-0899

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Evelyn Parsons
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Feb 22, 1913

8. AGE: Years: 35 | Months: 7 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: John Parsons
13. Birthplace: England

MOTHER
14. Maiden Name: May Kirby
15. Birthplace: Maryland

16 (a) Informant: John Parsons
(b) Address: 2748 Lively Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory: Parkwood
Location:

18 (a) Funeral director: Chas. E. Brown-Ent Sons
(b) Address: 118 W. Mt. Royal Ave Baltimore, Md.

19 OCT 02 1948 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948, at 2:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-9 1948, to 10-21 1948, and that I last saw h[illegible] alive on 10-21 1948

Immediate cause of death: Acute, ulcerative, colitis — Duration: 4 weeks
Due to: Pneumonia, with general peritonitis due to perforation of — 4 days
Due to: ulcer
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature: Vernon H Norwood M. D.
Address: Church Home Hospital Date signed 10-21-48

VS 153

67887 BC-48-23051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 67887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4/7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Brannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1948

8. AGE: Years 0 | Months 0 | Days 1day | If less than one day hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hugh Edward Brannon

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Dorothy Katherine Smith

15. Birthplace Phila., Pa.

16 (a) Informant Dorothy Brannon

(b) Address 800 N Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director J. G. IMUNEK FUNERAL HOME

(b) Address 1916 Madison St

OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1948 at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from morning 10-21-1948 to afternoon 10-21-1948 and that I last saw her alive on October 21, 1948

Immediate cause of death Premature infant & Respiratory & Cardiac death — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Bean, M.D.

Address Woman's Hospital Date signed 10-21-48

VS 190

G67888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G67888
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5924 Greenhill Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. WEILBRENNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Weilbrenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	7	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Adam Weilbrenner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ostertag
15. Birthplace Balto., Md.

16 (a) Informant Mrs. John A. Weilbrenner
(b) Address 5924 Greenhill Ave. Balto. 6, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director LASSAHN FUNERAL HOME
(b) Address 7401 Belair Rd.

19 OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948, at 2 A. M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage (traumatic)
TRAUMATIC

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-18-48 at 3:00 P. M.
(b) Where did injury occur? Home of John Lattie Westwood Ave.
(c) Did injury occur at home, on farm, industrial place, or public place? home While at work? no
(d) Means of injury Fell down steps inside

23. Signature Emil M. Beyer, M.D. Medical Examiner
Date signed 10-22-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

067889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. 67889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Tuxedo St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Webster Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-22-1318

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-9-29

8. AGE: Years	Months	Days	If less than one day
19	8	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Balto City Maintenance

FATHER
12. Name Clinton W. Green
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine C Roodge
15. Birthplace Balto Md

16 (a) Informant Father
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25-1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Maryland

18 (a) Funeral Director Durage Funeral Home
(b) Address 3631 Falls Road

19 OCT 22 1948 Washington Williams M.D. (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 21 - 1948, at 6:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 10-21-1948, and that I last saw him alive on 10-21-1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial Hemorrhage	20 hrs
Due to Thrombocytopenic purpura	8 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 10-21

VS 150

667890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 667890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Forbes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.) [illegible] 1908

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Md. ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name William Forbes
13. Birthplace ?

MOTHER 14. Maiden Name Liza Adams
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible]/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. E. Kelly Co.
(b) Address 1303 Pressman St

19 (a) Oct 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1948 to Oct 20 1948 and that I last saw her alive on Oct 20 1948

Immediate cause of death	Uremia	
Due to	Malignant nephrosclerosis	
Due to	Hypertensive cardiovascular renal disease	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation –
Major findings of operation: –
of autopsy: Hypertrophied heart, small kidneys

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury –

23. Signature John Collins Harvey
Address Johns Hopkins Hospital Date signed Oct 22 48

VS 150

X

G67891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G67891 Registered No.

Please write age if necessary important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 623-N Bethel

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 26 days

(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 623 N. Bethel St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Alsa Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52	?	?	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Unemployed Housewife

11. Industry or business

FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant Mrs Hermann B. Ross

(b) Address 902-N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location A.A. County

18 (a) Funeral director Mrs Cath. A. Elliott Dept.

(b) Address 1129 N. Carlton St.

19 (a) (b)

(Date received by Registrar) Registrar

Oct 22 48 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 10/18 1948 and that I last saw her alive on 10/18 1948

Immediate cause of death	Duration
Sub acute glomerulo Nephritis	
Due to Renal Insufficiency	
Due to	
Other Conditions Cardio-Vascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. E. Brady

Address 1514 Division St Date signed M. D. 10/20/48

VS 150

X

G67892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

484 Registered No. G67892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1875 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto:
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1875 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Marie Jones Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: C.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bailey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): 1/15/07
8. AGE: Years: 41 Months: 9 Days: 4 If less than one day hr. min.
9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business

FATHER
12. Name: Jessie Jones
13. Birthplace: Va.

MOTHER
14. Maiden Name: Adie Smith
15. Birthplace: Va.

16 (a) Informant: Elnora Collins
(b) Address: 1875 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Pk.
Location:

18 (a) Funeral director: Joseph D. Lockard
(b) Address: 1304 N. Central Ave

(a) Date received by registrar OCT 22 1948 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/19 1948 at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1947 to 10/19 1948, and that I last saw h[illegible] alive on 10/19 1948.

Immediate cause of death: Cancer Uterus — Duration: 10 Months
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Edith A. Lofred, M.D.
Address: 522 N. Bond St. Date signed 10/21/48

X

HH 4 67893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1572

✓ X

G67893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs. mos. or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charleston (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 542a Route #2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas O Hill
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-14-48

8. AGE: Years	Months	Days	If less than one day
	2	8	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Ralph Hill
13. Birthplace W. Va

MOTHER 14. Maiden Name Elizabeth Childs
15. Birthplace W. Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Charleston
Location West Virginia

18 (a) Funeral director Charles F. Towell
(b) Address 2427 Edmondson ave

OCT 22 1948 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948, at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1948 to 10-22 1948, and that I last saw him alive on 10-22 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Possible cerebral maldevelopment	
Due to	
Other Conditions Marasmus malaria	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of autopsy: Hyperemia of Lungs & Bronchi

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Markowitz MD
Address Johns Hopkins Hospital Date signed 10/22/48

VS 130

X

G67894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G67894
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18a 4days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dewitz, William Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8219A

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Widowed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1865

8. AGE: Years 83 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER
12. Name CHARLES DEWITZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Dewitz Jr
(b) Address 2723 W. FAIRMOUNT AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address 1600 Hollins St

19 (a) 0CT 22 1948 (Registered by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 | 21 | 1948, at 2:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20/1948 to 10/21/1948 and that I last saw him alive on 10/21/1948.

Immediate cause of death	Duration
Peritonitis	
Due to Gangrene of Bowel (entire Bowel)	
Due to Thrombosis of the Superior Mesenteric Vessel Vein	
Other Conditions Perforation of Ileum (Include pregnancy within 3 months of death)	

Date of operation 10/20

Major findings of operation: L.T.S. Above. Peritonitis: Perforation of Ileum

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard K. Kennedy M. D.
Address 1600 Hollins St Date signed 10/21/48

X

G67895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 001

Registered No. G67895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Clarke
(c) City or town RURAL Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Park (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Howard Ochs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1941

8. AGE: Years	Months	Days	If less than one day
7	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business Richard Henry Lee Elem. School

FATHER
12. Name Howard Lawrence Ochs
13. Birthplace Baltimore

MOTHER
14. Maiden Name Doris Marie Schline
15. Birthplace Brooklyn, Md.

16 (a) Informant: Mrs. Doris Ochs
(b) Address: Marley Park, Glen Burnie P.O. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cemetery
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) OCT 26 1948 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6/ 1948 to 10/22/ 1948 and that I last saw him alive on 10/22/ 1948

Immediate cause of death	Duration
Lueral Toxemia	
Due to Typhoid Fever	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ulcerations of intestines

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Persons, Jr. M.D.
Address D. Hopkins Hosp. Date signed 10/22/48

G67896

AB-123580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 130

G67896
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2838 Denham Circle, Cherry Hill
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2838 Denham Circle, Cherry Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalee Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7- 1932

8. AGE: Years	Months	Days	If less than one day
16	6	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Stevenson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Fennels
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-24-48
(Burial, cremation, or removal) Mt. Calvary (month) (day) (year)
(c) Cemetery or crematory
Location Brooklyn, Maryland

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue

19 (a) (Date rec'd by registrar) (b) Registrar
Lexington Williams, M.D.

OCT 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19- 1948, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948, to 10-17- 1948, and that I last saw her alive on 10-17- 1948.

Immediate cause of death	Duration
Uremia	
Due to sub-acute glomerulonephritis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. O. Wilson M. D.
Address BCH Date signed 10-21

G67897 ✓ G67897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 612 N. Carey St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 612 N. Carey St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Mrs Lee Wilson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Femal

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 26 1883

8. 65 Years 64 | Months 11 | Days 24 | If less than one day ..... hr ..... min.

9. Birthplace Blackstone Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER 12. Name Archer Williams

13. Birthplace Blackstone Va

MOTHER 14. Maiden Name Elvira Neal

15. Birthplace Blackstone Va

16 (a) Informant Mr. Clara Hardesty

(b) Address 612 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24. 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Arbutus Maryland

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly Ave.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) .....

Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 10 1948 to Oct. 20 1948. and that I last saw her alive on Oct. 20 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 3 month

Due to .....

Due to H.C.V.

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Geo. J. McDonald M. D

Address 344 N. Carey St Date signed 10/22/48

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

G67898 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: RUTH NEWTON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-1918

8. AGE: Years 30 | Months 8 | Days 5 | If less than one day: hr. min.

9. Birthplace: Petersburg, Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Mathew Garrett
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Emma Jones
15. Birthplace: Virginia

16 (a) Informant: Albert Newton (H)
(b) Address: 1409 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22-48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l Pk.
Location: Baltimore County, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 512 Carrollton Avenue

19 (a) Filed by registrar (b) Registrar: Remington Williams M.D.

VS (5)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948, at 2:20 PM

21. I certify that I took charge of the remains described above, held an Insp & Inquiry (Autopsy, Inspection or Inquiry) thereof and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: 1st and 2nd degree burns 60% body

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-48 at 11:50 P M.
(b) Where did injury occur? 1409 Madison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: 2nd flr of home afire--trapped in room

23. Signature: C. P. Lubenske M.D. Medical Examiner.
Date signed 10-19-48

X

667899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 667899

667899

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 Cliftwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Cliftwood Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Pickel

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	10	3+		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired - Packer

11. Industry or business Retail Furniture

FATHER
12. Name George H. Pickel
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Meier
15. Birthplace Germany

16 (a) Informant J. Earl Pickel
(b) Address 4233 Sheldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co.

18 (a) Funeral director Mrs. Mrs. John W. Pickel's Son
(b) Address 5311 Edmondson Ave

19 OCT 22 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1947 to 10/20 1948
and that I last saw h[illegible] alive on 10/20 1948

Immediate cause of death: Bronchopneumonia — Duration: 2 days
Coronary Sclerosis
Due to Arteriosclerosis
Hypertension Cerebrovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Mesa M. D.
Address 1427 E North Ave Date signed 10/21/48

V S 150

X

67900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

67900 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution:
Bellona and Belvidere ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Bawleys Land
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Katawski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Stella Katawski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 15 1887

8. AGE: Years	Months	Days	If less than one day
61	1	6	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Carpenter B. O. R. R. Co.

11. Industry or business

FATHER 12. Name	Baltazar Katawski
FATHER 13. Birthplace	Poland
MOTHER 14. Maiden Name	Mary Makowski
MOTHER 15. Birthplace	Poland

16 (a) Informant Mrs Stella Katawski
(b) Address 4502 Bawleys Land

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (Cem)
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 407 S. Chester Street

19 OCT 22 1948 (Date rec'd by registrar) Registrar Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 12 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 16 1948 to Oct 21 1948.
and that I last saw him alive on Oct 20. 1948

	Duration
Immediate cause of death Bronchial pneumonia	2 days
Due to Acute Bronchitis	2 wks.
Due to Hardening of arteries	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature N. M. Darwood M. D.
Address 1136 Park Ave Date signed 10/24/48

VS 3

667901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 dr Registered No. 667901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2728 Ruggles Ave
(c) Hospital or institution:
Md University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2728 Ruggles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Ehrlich

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Walter Ehrlich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 - 1874?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	2	7		

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustav Doggl
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Walter E
(b) Address Lansdowne Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Edw Faulmann
(b) Address 2228 Frank Blvd.

19 (a) OCT 22 1946 Huntington Williams MD
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946, at 1 32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Oct 21 1946, and that I last saw h alive on Oct 21 1946

Immediate cause of death: respiratory failure

Due to lipoid pneumonia

Due to

Other Conditions Carcinoma of Colon

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank E Wigglesworth
Address University Hospital Date signed 10/21/46 M D

111c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1/2 -

Registered No. G67902

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 625 Cokesbury Ave. If rural give location

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Dolores Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 21, 1929

8. AGE: Years	Months	Days	If less than one day
18	10	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tailoress

11. Industry or business

FATHER

12. Name William Joseph Cook

13. Birthplace Maryland

MOTHER

14. Maiden Name Josephine Cook

15. Birthplace Maryland

16 (a) Informant HOSPITAL RECORDS

(b) Address Union Memorial Hospt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer City

Location

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREENMOUNT AVE & 22ND

19 (a) OCT 22 1948 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948, at 10:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1948 to Oct. 20 1948, and that I last saw h alive on Oct. 20 1948

Immediate cause of death	Duration
Congestive heart failure	6 mo.
Due to Rheumatic fever	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John R. Smith, Jr. M.D.

Address Union Mem. Hosp Date signed 10/20/48

VS 189

667903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 667903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 Ensor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Ensor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Mildred A. Chandler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8- 1924

8. AGE: Years: 24 | Months: 7 | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Robert L. Chandler
13. Birthplace Va

MOTHER 14. Maiden Name Blanche Morrow
15. Birthplace Va

16 (a) Informant Blanche Chandler
(b) Address 712 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-1948 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-48 to 10-19-1948 and that I last saw her alive on 10-19-1948.

Immediate cause of death: Bronchio Pneumonia — Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M.D.
Address 1603 N. Caroline Street
10-21-48

V S 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. Every item of

G67904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0134 Registered No. G67904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 W. Mosher st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 W. Mosher st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellenie Victoria Jones Hall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	married

6 (b) Name of husband or wife Charles Hall
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Florence S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Lucious Jones
13. Birthplace S.C

MOTHER
14. Maiden Name Viner Singletary
15. Birthplace S.C

16 (a) Informant Otis C Jones
(b) Address Loudred Lowell Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto County

18 (a) Funeral director Carpenter & Sanders
(b) Address Preston & Eutaw

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Registrar

Remington for Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1948 at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1948 to 10/19 1948.
and that I last saw her alive on 10/18 1948.
Immediate cause of death Pulmonary Tuberculosis — Duration 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauner
Address 1111 Sea Date signed 10/19/48 (M. D.)

VS 150

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G67905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 N. Eulaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Eulaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. A. Floeck

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0398

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mabelle M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1888

8. AGE: Years 60 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Steel Corp

FATHER
12. Name Fritz Floeck
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Schlauch
15. Birthplace U. S. A.

16 (a) Informant Mrs. Mabelle Floeck
(b) Address 130 N. Eulaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location East, Balto. Co. Md.

18 (a) Funeral director Harry H. Fritze
(b) Address 410 Edmondson Ave

19 (a) Oct 22 1948 (b) Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20/48 19 , at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Oct 1948 and that I last saw h[illegible] alive on Oct 18 1948.

Immediate cause of death: Arteriosclerotic C.V. disease — Duration 4 yrs.
Due to:
Due to:
Other Conditions Bronchopneumonia — 2 weeks.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Fulweiler M. D.
Address 1946 N. Calvert Date signed 10/21/48

PRINCE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

667906 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 338 S. Bentalou
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 S Bentalou
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle C Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7391

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 25, 1909

8. AGE: Years 39 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation SEWING MACHINE OPERATOR

11. Industry or business BUD COAT Co.

FATHER
12. Name John Brandau
13. Birthplace Maryland

MOTHER
14. Maiden Name Lilley Krowey
15. Birthplace Maryland

16 (a) Informant Mr. James Bailey
(b) Address 121 S. Monroe Street

17 (a) BURIAL (b) Date thereof OCT. 23 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location 3801 FREDERICK AVE.

18 (a) Funeral director Harry A Wiltse
(b) Address 4101 Edmondson Ave

19 (a) OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1948, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-20-48 at 3:30 P. M.
(b). Where did injury occur? 338 S. Bentalou Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners and oven on on stove

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 10/20/48

VS 151

667907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 e

Registered No. 667907

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE M. WARRENBERGER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife George W. Warrenberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 14 1870

8. AGE: Years	Months	Days	If less than one day
78	1	6	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George W. Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Hancock
15. Birthplace Md.

16 (a) Informant Mrs. Etta Harig
(b) Address 714 Frederick Ave., Catonsville

17 (a) Burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1948, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948, to Oct 20 1948, and that I last saw h[illegible] alive on Oct 1 1948.

Immediate cause of death Interstinal Strangulation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. J. Tuttleman M. D.
Address 7327 Reisterstown Rd Date signed 10/21/48

VS 150

G67908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 South Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT H. WEIS

3 (b) If veteran, name war: –

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada Baltzley Weis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1886

8. AGE: Years	Months	Days	If less than one day
62	4	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business U. S. Printing & Lithograph

FATHER
12. Name Louis T. Weis
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret C.
15. Birthplace Baltimore

16 (a) Informant Mr. C. K. Poske
(b) Address 2311 South Rd., Balto. 9, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICHER & SONS
(b) Address Balto., Md.

19 (a) OCT 22 1948 (b) Huntington Williams, M.D.
(To be filled in by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Oct 16 1948, and that I last saw h[illegible] alive on 10-16 1948

Immediate cause of death
Coronary Heart Disease
Coronary Thrombosis
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 4 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Nelson Carey M. D.
Address 1014 St Paul St Date signed 10-22-48

VS 150

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any information should be clearly supplied. The

G67909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G67909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Thames Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELVEN HARVEY PITTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1909

8. AGE: Years 39 | Months 1 | Days 15 | If less than one day: hr. min.

EW

9. Birthplace Highlands, N. J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pittman
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Grace Johnson
15. Birthplace U. S. A.

16 (a) Informant Mrs. Harry Nyman
(b) Address 331 - 79th St., North Bergen, N. J.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-23-48 (month) (day)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH October 17, 1948 at 10:25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Intracranial hemorrhage.
Due to Contusion of brain

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-48 at M.
(b) Where did injury occur? Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Fell to ground and struck head during altercation

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 10/18/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67910 ✓ G67910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

061 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 Rutland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Widow

6 (b) Name of husband or wife Williams 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 29, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	21	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Walter Perry
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Ann Perry
15 Birthplace D.C.

16 (a) Informant Walter Smith
(b) Address 1706 E. Eager St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 22/48 (month) (day) (year)
(c) Cemetery or crematory
Location Raleigh N. C.

18 (a) Funeral director Mrs. Pott. A. Elliott & Sons
(b) Address 1129 N. Gaylord St.

19 (a) Oct 22 1948 (Date rec'd by Reg'r) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948 at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948 to 10/20 1948 and that I last saw h[illegible] alive on 10/20 1948

Immediate cause of death
Bronchopneumonia
Due to Diabetes Mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ella L Lafond M. D.
Address 522 N. Bond St Date signed 10/22/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1861

Registered No. 67911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 New Battle grove Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VERNON BERNARD BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1948

8. AGE: Years | Months: 9 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Willie M. Brown
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Theresa Brown
15. Birthplace: Maryland

16 (a) Informant: Willie M. Brown
(b) Address: 110 Newbattle Grove Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Elm
Location B. B. Co Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1050 Monty omery St

OCT 23 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1948, at 8.02 a.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-48 at approx. 7.30 a. M.
(b) Where did injury occur? Route 20, Newbattle Grove
(c) Did injury occur at home, on farm, industrial place, in public place? home While [illegible]? no
(d) Means of injury Icebox fell over on head

23. Signature [signature] M.D. Medical Examiner
Date signed October 21, 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G67912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL, and give town)
(d) Street No. 261 Baltimore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. BLANKENSHIP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Gladys Blankenship
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Electrician's helper
11. Industry or business

FATHER
12. Name Isaac Stephen
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma J. Snivley
15. Birthplace Ohio

16 (a) Informant Mrs. Gladys Blankenship
(b) Address 261 Baltimore Ave., Dundalk

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 25, 1948 (month, day, year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7922 EASTERN AVE.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) OCT 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 8.40 A M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward L. Ryan M.D. (Medical Examiner)
Date signed October 22, 1948

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 67913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5015 Roland Avenue
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5015 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C. BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sophie Gaither
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) 9/2/1892

8. AGE: Years	Months	Days	If less than one day
56	1	19	..... hr. ..... min.

9. Birthplace Baltimore, Baltimore, Mary (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John E. Briscoe
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary Crawford
15. Birthplace Baltimore, Maryland

16 (a) Informant Patient
(b) Address 5015 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. John's
Location Ellicott City, Md.

18 (a) Funeral director John O. Whitehill & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (Date received by local registrar) OCT 23 1948 Huntington Williams, M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1948 at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 8, 1948. to October 21, 1948. and that I last saw him alive on October 21, 1948.

Immediate cause of death Bronchogenic Carcinoma, Rt. Lung

Due to

Due to

Other Conditions Metastasis in liver + pleura

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Glenn P. Grow M.D.
Address Union Memorial Hospital Date signed 10/24/48

67914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. 67914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Monroe (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Eigler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Henry E. Eigler, Sr. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1885

8. AGE: Years	Months	Days	If less than one day
63	2	3	hr. min.

9. Birthplace Ellicott City, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William C Brodbeck
13. Birthplace Unknown

MOTHER
14. Maiden Name Rachel M. Hatfield
15. Birthplace Unknown

16 (a) Informant Henry E. Eigler Jr.
(b) Address 225 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Mausoleum
Location Balto., Md.
18 (a) Funeral director W. J. TICHNER & SONS
(b) Address Baltimore, Md.
19 OCT 23 1948 (Date rec'd by registrar) (b) Kenneth Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 - 1948, at 8 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 - 1948, to Oct 21 1948, and that I last saw her alive on Oct. 20 1948.

	Duration
Immediate cause of death Cerebral Hemorrhage	Sept. 5. 1948
Due to Chr. Myocarditis	1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul H Brown
Address 1663 W. North Av. Date signed 10/21/48 M. D.

VS 130

G67915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Isreal Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Middlesex Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Taylor
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Isreal Smith
(b) Address 3221 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna ave

19 (a) [illegible] Huntington Williams, M.D. Registrar

OCT 28 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1948 to Oct 21 1948, and that I last saw h[illegible] alive on Oct 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 Greenfield Date signed 22 Oct 48

VS 150

Please answer all questions; especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Swayer
67916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131

Registered No. G67916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 Christopher Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Christopher Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Daniel Fisher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	26	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Machinist-Retired
11. Industry or business Crown, Cork, & Seal

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mamie Fisher
(b) Address 2822 Christopher avenue

17 (a) Burial (b) Date thereof 10-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenhill Cemetery
Location Waynesboro, Penna
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14
19 (a) OCT 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to Oct 22 1948 and that I last saw him alive on Oct. 21 1948.

Immediate cause of death: Hypertensive Heart Disease — Duration: 5 years
Due to
Due to
Other Conditions: chronic nephritis — Duration: 3 years.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Geo. Dunyer M. D.
Address 4808 Harford Rd Date signed 10/22/48

937

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164

667917 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID FRANKLIN BRUCHEY

3 (b) If veteran, name war: War II

3 (c) Social Security Account No. 216-18-7177

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1924

8. AGE: Years	Months	Days	If less than one day
24	1	14	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto., Transit

FATHER
12. Name William F. Bruchey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth B. Metzler
15. Birthplace Balto.

16 (a) Informant: William F. Bruchey
(b) Address 1331 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory New National
Location Balto., Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) OCT 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948 at 9:45PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 21/48 Approx. 9:14 P.M.
(b) Where did injury occur? 1331 W. Pratt
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D. Medical Examiner
Date signed 10/22/48

VS 151

G67918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67918 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 ST. PAUL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 ST. PAUL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LELIA P. TILYARD

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife JOHN S. TILYARD.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 19, 1870

8. AGE: Years 78 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation
11. Industry or business HOME

FATHER
12. Name JOHN T. RIDDLE
13. Birthplace MD.

MOTHER
14. Maiden Name MARY E. WARD.
15. Birthplace MD.

16 (a) Informant MRS. MOLLIE T. CAMPBELL
(b) Address 2622 ST. PAUL ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT. 25, 48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 EDMONDSON AVE

19 (a) OCT 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Oct 1948, at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 30 1948 to Oct 22 1948 and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis
Due to: Senile Arteriosclerosis
Due to:
Other Conditions: Chronic Malnutrition
(Include pregnancy within 3 months of death)

Duration: 10 D.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N. Charles St. Date signed 23 Oct 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93-

Registered No. G67919

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5113 Whitelford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 Whitelford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willy Benny

3 (b) if veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minna C. Benny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 5 1865

8. AGE: Years	Months	Days	If less than one day
85	0	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Wm Oscar
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Flamm
15. Birthplace Md.

16 (a) Informant Minna C. Benny
(b) Address 5113 Whitelford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location No

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Baltimore St

19 (a) OCT 23 1948 (Date received by registrar) (b) Huntington Nelson (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 22 1948, and that I last saw h IM alive on Oct 22 1948

Immediate cause of death: Cardio-vascular Disease — Duration 1 Yr.
Due to: Arterio Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Emmett Logan M. D.
Address 101 N. Read St. Date signed 10-25-48

667920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667920 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Sea View Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Edward Lucas

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 19, 1921

8. AGE: Years: 26 | Months: 11 | Days: 1 | If less than one day: hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Damian Lucas
13. Birthplace Hanover, Va.

MOTHER
14. Maiden Name Lena Ball
15. Birthplace Richmond Va

16 (a) Informant Lena Lucas
(b) Address 1220 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Columbus Memorial Park
Location Balto County Md

18 (a) Funeral director Chas H. Sparks
(b) Address 512 Carroll St

19 (a) OCT 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 1948, at 6:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-[illegible] 1947 to 10-20 1948, and that I last saw h[illegible] alive on 10-20 1948.

Immediate cause of death Coronary Occlusion
Duration: ?
Due to Arteriosclerosis
Due to
Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-23-48

VS 190

G67921

ES-123557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

§ 3a

G67921
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve Moutrey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Eugene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/18/1902

8. AGE: Years	Months	Days	If less than one day
46	4	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John H. Jenifer
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Clark
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk
Location Balto. County, Md

18 (a) Funeral director Charles G. Co[illegible]r
(b) Address 512 N. Carrollton Ave

19 (a) OCT 23 1948 (Date rec'd by registrar) Huntington M[illegible], Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 19 48 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6- 19 48 to 10-19- 19 48
and I last saw her alive on 10-19 19 48

Immediate cause of death: Sub-arachnoid hemorrhage — Duration 13 d
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. F. Nelson
Address Date signed 10-19-48 M. D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G67922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St
(If rural give location)
(e) Citizen of foreign country? Niesbaden. (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Sr.M;Paterna (Duesel)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9th. 1880

8. AGE: Years	Months	Days	If less than one day
67	10	13	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business N. D. C. School

FATHER
12. Name George Duesel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Friess
15 Birthplace Baltimore Md.

16 (a) Informant Sr. M. Stan. Kostka.
(b) Address 901 Aisquith. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25th. 48 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glen Arm.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N Wolfe. St.

19 (a) Oct 24 1948 (Date Rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22nd. 1948, at 1pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7th 48 to Oct. 22th 48
and that I last saw her alive on Oct 21st 48

Immediate cause of death	Duration
Arterio sclerosis Chr Myocarditis	
Due to Cerebral embolus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J Kirby Rel Supt
Address 110 E. North Ave Date signed 10-26-48

V S 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G67923 Registered No. 83a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Westown (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Wohlrab, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1-1-87

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61				

9. Birthplace Austria (Town, county, and State)
10. Usual Occupation 1st class Factory
11. Industry or business

FATHER 12. Name Karl Wohlrab
13. Birthplace Austria

MOTHER 14. Maiden Name Anna Bower
15. Birthplace Austria

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Westown, W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address No. 4 Pa. Aves. Balt 17, Md.

OCT 24 1948 (Date rec'd by registrar) (b) Tomlinson Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1948 to 10-23-1948 and that I last saw him alive on 10-23-1948

Immediate cause of death Cerebrovascular accident — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Gardner M. D.
Address Johns Hopkins Date signed 10/23/48

VS 150

G67924
That

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 441 Registered No. G67924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn #19 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 44th St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Skoorka

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) [redacted] of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-11-23

8. AGE: Years 25 | Months 9 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business

FATHER 12. Name David Skoorka
13. Birthplace Poland

MOTHER 14. Maiden Name Rosa Reiberman
15. Birthplace Poland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location New York N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 104 Eutaw Place

OCT 24 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1948 at 10000 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 10-23 1948 and that I last saw her alive on 10-23 1948

Immediate cause of death Respiratory Failure — Duration

Due to Bronchial Obstruction

Due to Hodgkin's Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Crow M. D.
Address Johns Hopkins Hosp. Date signed 10-23-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9rd

G67925 **Registered No.**

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Battery ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Battery ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Padden

3 (b) If veteran, name war | 3 (c) Social Security Account No. 219-14-0175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/15/1885

8. AGE: Years	Months	Days	If less than one day
62	11	7	hr min

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Bar-Tender

11. Industry or business

FATHER
12. Name Patrick Padden
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Rose Padden
(b) Address 1519 Battery ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1848 Light St.

19 (a) OCT 24 1948 (b) Burlington Williams Md
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from June 5 1948 to October 22 1948, and that I last saw him alive on Oct 22 1948

Immediate cause of death	Duration
Chronic Endocarditis	6 mos.
Due to — arteriosclerosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. B. Mellott M. D.
Address 1279 Williams N Date signed 10/23/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67926
AB-123597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93d

G67926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 51

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 67yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 285 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9-1880

8. AGE: Years	Months	Days	If less than one day
68	✓	✓	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Henry Williams (D
13. Birthplace West Indies

MOTHER 14. Maiden Name Mary ? (D
15. Birthplace West Indies

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenmore Hill Rd

18 (a) Funeral director Dietrich & Young
(b) Address 318 Light St

19 (a) Lavinia Williams, Mo
(Date rec'd by registrar) Registrar

OCT 24 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11- 1948, at 3.30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-8- 1948, to 10-11- 1948, and that I last saw h im alive on 10-11- 1948

	Duration
Immediate cause of death Pulmonary Edema	5hr.
Due to Cardiac failure	2 wk.
Due to Hypertensive Cardiovascular disease	2-3 yr.
Other Conditions Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S Stutzman M D
Address Balto. City Hosp Date signed 10-22-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67927
LCH-108892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G67927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs. 7 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Laurens Street 17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME May Ijam — May M. Ijams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George W Ijams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1859

8. AGE: Years	Months	Days	If less than one day: hr.	min.
89	7	14		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Cassandra Daniels
15. Birthplace Md.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry Klumpp
(b) Address 4207 Ridgewood Ave

19 (a) Oct 24 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 (Month) (Day) (Year) at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/47 to 10/20/48, and that I last saw her alive on 10/20/48

Immediate cause of death	Duration
Pulmonary embolism	Questionable
Due to Hypertensive arteriosclerotic heart disease & failure	
Due to Phlebothrombosis left leg.	2 mos
Other Conditions Bronchopneumonia Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: [redacted] not done

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature David H. Wagner
Address Balto City Hosps (Date signed) 10-23-48

VS 19

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G67928 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 N ELLAMONT ST (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADOLPH P. KRIEGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT-24-1880

8. AGE: Years 68 | Months 0 | Days 28 | If less than one day: hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation BUTCHER

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant OTTO KRIEGER
(b) Address 40 N. ELLAMONT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 25 48 (month, day, year)
(c) Cemetery or crematory LORRAINE PARK CEM
Location

18 (a) Funeral director THOMAS J. KENNY INC
(b) Address 1600 HOLLINS ST

OCT 24 1948 (Date received by registrar) by Clayton Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/48 19 at 5:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from, natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature John L. Davis, Medical Examiner. M.D.
Date signed 10/23/48

VS 151

B.C. G67929
B.C. 48-2296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G67929
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2
(c) Hospital or institution: Mercy Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Fitz Gerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1948

8. AGE: Years | Months | Days | If less than one day 9 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Premature

11. Industry or business

FATHER
12. Name Everett C. Fitz Gerald Jr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Hazel Mae Albrecht
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address 304 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2422 Edmondson Ave

OCT 24 1948
(Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 A.M. Oct 21 1948 to 3:45 Oct 21 1948, and that I last saw him alive on Oct 21 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions 5 Lunar Pregnancy (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Bacon Jr. M. D.
Address Mercy Hospital Date signed 21 Oct 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G667930

AB-123881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

Registered No. G667930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bindeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-1874

8. AGE: Years	Months	Days	If less than one day
74	1	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Charles Bindeman
13. Birthplace ~~Maryland~~ Germany

MOTHER
14. Maiden Name Agnes Brown
15. Birthplace ~~Maryland~~ Germany

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location old Frederick Road

18 (a) Funeral director Charles W Lachenmyer
(b) Address 703 McHenry St

19 (a) OCT 24 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21- 1948 at 12.10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20- 1948 to 10-21- 1948, and that I last saw him alive on 10-21- 1948

Immediate cause of death	Duration
Acute myocardial infarction, post.	4 days
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Vinkes Jr. M.D.
Address Balto City Hosp Date signed 10/26/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B. C. 667931 48-7824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15a

667931 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3804 Woodbine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Woodbine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Carl Tatelbaum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
2 mo			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Hyman
13. Birthplace Russia

MOTHER 14. Maiden Name Freda
15. Birthplace Poland

16 (a) Informant Hyman Tatelbaum
(b) Address 3804 Woodbine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Shirley

18 (a) Funeral director Jack Levin Inc
(b) Address 1100 Eutaw Place

OCT 24 1948 (Date received by registrar) Huntington Williams, M.D. (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1948 at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lubowski M.D. (Medical Examiner.)
Date signed 10/24/48

X

VS 181

G67932 3C-48-2321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G67932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore #17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Hannah St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bond

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) 10-17-48

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Emory Bond, Jr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Felicia Satchell
15. Birthplace Baltimore, Maryland

16. Informant Mother, Felicia Bond
Address 1815 N. Hannah St.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory University Medical School OCT 22 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 OCT 25 1948 (Date rec'd by Registrar) Huntington Millmore M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct 19 1948.
and that I last saw h alive on 10-17 1948.

Immediate cause of death Atelectasis — Duration 24 hrs.
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Rann M. D.
Address University Hospital Date signed 10-22-48

G67933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G67933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 0th
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34½ hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Clemmons

3 (b) If veteran, name war

3 (c) Social Security Account No. 225-05-7049

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of ~~husband or~~ wife Margaret Clemmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26th 1902

8. AGE: Years 45 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business National Paving Co.

FATHER
12. Name Wm G. Clemmons
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Va.

16 (a) Informant Margaret F. Clemmons
(b) Address 2137 Linden Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 25 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar) Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1948, at 6 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1948, to 10/23 1948, and that I last saw him alive on 10/22 1948.

	Duration
Immediate cause of death: Cardio-respiratory failure	1 day
Due to Cerebro-vascular Accident	1½ days
Due to	
Other Conditions Pulmonary edema	1 day

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland General Hosp. Date signed

VS 180

G67934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Gilmor & Saratoga
(b) Street address ~~Old Pimlico~~
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Quincy Warner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife Jeane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-84

8. AGE: Years	Months	Days	If less than one day
64	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ephraim ~~Walter~~ Warner
13. Birthplace Pa.

MOTHER
14. Maiden Name Sally Weaver
15. Birthplace Pa

16 (a) Informant Susan Warner (sister)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc.
(b) Address 12 E. Pleasant

19 (a) OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1948, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21- 1948 to 10-23- 1948 and that I last saw him alive on 10-23 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Anemia	
Due to Chronic arteriosclerotic nephritis	Uncertain
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allyn F. Jackson M.D.
Address Mercy Hospital Date signed 10-25-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46a ✓ Registered No. G67935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Light St.
(c) Hospital or institution: South Balto. Genl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 West Bay Cir (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Morris

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-04-1845

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Augusta Morris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 8th 1884
8. AGE: Years 64 | Months 6 | Days 15 | If less than one day: hr min.
9. Birthplace: Denmark (Town, county, and state)
10. Usual Occupation: Mill wright
11. Industry or business: Southern Spars Corp.

FATHER
12. Name
13. Birthplace: Denmark

MOTHER
14. Maiden Name: ?
15. Birthplace: Denmark

16 (a) Informant: Mrs. Augusta Morris
(b) Address: 3708 West Bay Cir

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Balto Co. Md.

18 (a) Funeral director: Williams Co.
(b) Address: 121 E. Saratoga St.

19 OCT 25 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948 at 4:30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 27, 1948 to Oct 23, 1948, and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death	Duration
Emphysema, bilateral + massive	5 days.
Due to	
Due to	
Other Conditions: Carcinoma Oesophagus	

(Include pregnancy within 3 months of death)

Date of operation Oct. 12, 1948
Major findings of operation: Carcinoma Upper 3rd Oesophagus
of autopsy: Bilateral massive emphysema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 1713 Light Street Date signed 10-26-48

VS 150

110a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

× ✓ G67936 55e Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Clearview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne A
(c) City or town Dorsey (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha M. Heil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Philip Heil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1895

8. AGE: Years	Months	Days	If less than one day
53	9	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Smallwood
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Smallwood
15 Birthplace Maryland

16 (a) Informant Philip Heil
(b) Address Dorsey, Maryland

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory St. Lawrence
Location Jessup, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1948 to Oct 22 1948 and that I last saw her alive on Oct 22 1948.

Immediate cause of death	Duration
Lymphosarcoma with Metastases	5 years
Due to	
Due to	
Other Conditions Anemia, and Cardiac Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 10-23-48

VS 150

G67937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G67937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St. 3
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 E. 27th (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Garretson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 21, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	2	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Bolton
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Baltimore, Md

16 (a) Informant Edward Garretson
(b) Address 431 E. 27th st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 OCT 25 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948. to Oct 23 1948. and that I last saw her alive on Oct 23 1948.

Immediate cause of death: Cerebro Vascular Accident — Duration

Due to: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature William E Beaven M. D.
Address Union Memorial Hosp Date signed 10-23-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G67938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67938

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon. Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts # 206 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Irvin G. Kroll

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-0599

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
M	W	

6 (b) Name of husband or wife Mrs. Ethel Kroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14-1894

8. AGE: Years	Months	Days	If less than one day
53	11	10	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Plant Supt
11. Industry or business C & P. Telephone Co.

FATHER
12. Name Adolph Kroll
13. Birthplace Md

MOTHER
14. Maiden Name Annie Gwynn
15. Birthplace Md.

16 (a) Informant Mrs Ethel Kroll
(b) Address Ambassador Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave.

18 (a) Funeral director Wm Cook Dye
(b) Address 1217 St Paul St

19 (a) OCT 25 1948 (Date received by Registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/24 1948, and that I last saw him alive on 10/24 1948

Immediate cause of death: Cerebral Hemorrhage
"Cerebral vascular accident"
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp. Date signed 10/24/48

X

667939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83d

667939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7000 W. North St.
(c) Hospital or institution:
Home for Incurables 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Hooker, Mrs Edith Houghton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Dr. Donald R. Hooker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1879

8. AGE: Years	Months	Days	If less than one day
68	10	2	hr. min.

9. Birthplace Buffalo, N.Y.
(Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Alfred A. Houghton
13. Birthplace Buffalo, N.Y.

MOTHER
14. Maiden Name Caroline Gansinghouse
15. Birthplace Buffalo, N.Y.

16 (a) Informant Records – Wm. Wharton
(b) Address 7000 W. North St. – Balto. Md

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 10 25 48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTO.

18 (a) Funeral director H. W. JENKINS & SONS CO.
(b) Address 4905 YORK RD.

19 (a) OCT 25 1948 (Date received by Registrar) (b) Farrington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1948, at 2-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1944 to 10/23 1948, and that I last saw him alive on 10/23 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 Days
Due to Hemiplegia (right)	8 years
Due to Arteriosclerosis (Generalized)	8 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Sexton Hersperger M. D.
Address 214 Medical Arts Bldg Date signed 10/24/48

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1216 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester Drummond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	6	hr min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Bagwell
13. Birthplace Unknown

MOTHER
14. Maiden Name Hester Savage
15. Birthplace Va.

16 (a) Informant Mrs. Ruth Bishop
(b) Address 1216 McCulloh St.

17 (a) Burial (b) Date thereof 10-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 25 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20-48 19 to Oct 22 1948. and that I last saw h alive on Oct 22-48

Immediate cause of death: Cerebral Hemorrhage — Duration 3 or 4 hrs.
Due to Senility, debility —
Due to Pneumonitis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. N. Cardozo M. D.
Address 524 Druid Hill Ave (Date signed) 10-25-48

VS 150

G67941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67941

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Overlea Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Kaltenbach
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Martha
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/29/91
8. AGE: Years 57 | Months 1 | Days 25 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Banking
11. Industry or business

FATHER
12. Name Gottlieb Kaltenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Christ
15. Birthplace Germany

16 (a) Informant Mrs. George Kaltenbach
(b) Address 13 E. Overlea Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Lancaster Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Oct 24 1948 and that I last saw h[illegible] alive on Oct 24 1948

Immediate cause of death: Acute Pulmonary Edema — Duration: 2 hrs
Due to Arterio-Sclerotic Heart Disease — 6 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Michael J. Drusch, M. D.
Address 13 E. Overlea Ave Date signed 10/24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Gatch

667942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Y 667942

Registered No. 1315

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Towson (If outside city or town limits, write RURAL and give town)

(d) Street No. 4 Greenbrier (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Benton R. Gatch

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-10-022[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Genevieve Gatch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 27, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57 yrs	1	29		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Vice Pres Paving supply & equipment Co

11. Industry or business

FATHER 12. Name Frank R. Gatch

13. Birthplace Maryland.

MOTHER 14. Maiden Name Ellen P. Evans

15. Birthplace Maryland

16 (a) Informant Mrs. Benton R. Gatch

(b) Address 4 Greenbrier Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) OCT 25 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1945. at 7:04 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1945. to Oct. 23 1945. and that I last saw him alive on Oct. 23 1945.

Immediate cause of death	Duration
Uremia	
Due to Chr. glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature John A. Clarson M. D.

Address Union Memorial Hospital Completed 10/24/45

VS 150

X

67943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pennsylvania RR Station
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) transient

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Dixie Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HAROLD MORGAN NESS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Ullrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	7	7		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Vice-President
11. Industry or business Swan Shoe Company, Inc.

FATHER
12. Name Charles Morgan Ness
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sara Frances Wahmann
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna U. Ness
(b) Address 329 Dixie Drive, Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month, day, year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John S. Mitchell Sons
(b) Address 1900 Eutaw Place, Balto.

19 (a) OCT 25 1948 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, at 12.30a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions (include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? What was it?
(d) Means of injury

23. Signature Emil L. Rzy M.D. (Medical Examiner)
Date signed October 24, 1948

VS 181

667944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1814 Maryland Ave

(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1814 Maryland Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick E. Venerable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-1892

8. AGE: Years	Months	Days	If less than one day
56	9	23	hr. min.

9. Birthplace Farmville, Va.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name George Venable

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Venable

15. Birthplace Va.

16 (a) Informant Mable F. Luby

(b) Address 1823 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto. City

18 (a) Funeral director Charles H. Chew

(b) Address 802 Madison Ave

19 (a) OCT 25 1948 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1948 to 10/21 1948 and that I last saw h[illegible] alive on 10/21 1948

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B. M. Klutts

Address 734 Dumont Hill Date signed 10/24/48

B. M. Klutts X

VS 150

G67945 BC

L 48-2024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G67945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals. 3 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Caroline Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Byrd-Ophelia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Ophelia Moses
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-16-48 9 AM (month) (day) (year)
(c) Cemetery or crematory B.C.H. crematory
Location 4940 Eastern Ave

18 (a) Funeral director B.C.H. Crematory
(b) Address

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948, at 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1948 to Sept. 13, 1948, and that I last saw him alive on Sept. 13, 1948.

Immediate cause of death Prematurity — Duration 36 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Stat Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address BCH Date signed 9-16-48

VS 150

G67946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a ✓ Registered No. G67946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 804 N Chester

(c) Hospital or institution: 7-05

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 804 N Chester (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence E Albert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Johanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1865

8. AGE: Years 83 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Asst Drinks Mfg

11. Industry or business retired

FATHER 12. Name John Albert

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mrs Edna Kirkwood

(b) Address 2217 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25/48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Ulman Funl Home

(b) Address 2008 Orleans St

19 (a) Oct 25 1948 (Date rec'd by Local Registrar) (b) Huntington Williams (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 8 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 19 48 to Oct 22 19 48, and that I last saw h alive on Oct 22 19 48.

Immediate cause of death	Duration
(a) Acute Dilatation of the Heart	
Due to (b) Chronic Myocarditis	
Due to (c)	
Other Conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dwight E Beidler

Address 2323 E Balto Date signed Oct 23 48

VS 150

93d

67947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. 67947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 N. Milton Ave.
(c) Hospital or institution:
6-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Paul Gregloit

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna E. Gregloit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1881

8. AGE: Years	Months	Days	If less than one day
67	4 3	7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Penna. R.R.

FATHER
12. Name ---Gregloit
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Edna E. Gregloit
(b) Address 118 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto., Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1948 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 18 - 1948 to Oct. 22 - 1948.
and that I last saw him alive on Oct 22 - 1948.

Immediate cause of death
Cardio Vascular Renal
Due to Myocardial Insufficiency
Due to Pulmonary Edema
Other Conditions Acute Cystitis

Duration
5 yrs.
5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. E. Gregloit M.D.
Address 15 E. Mulberry St. Date signed 10-23-48

X

G67948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67948

Registered No. 476038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 6 E

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 dys

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1701 N. Washington St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** John C. Rogers (JOHN CLAUDE ROGERS)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-07-2261

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jane H. Rogers

6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr): 11-8-89

8. AGE: Years: 58 | Months: 11 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Harford County Maryland (Town, county, and state)

10. Usual Occupation: Treater - S. Oil

11. Industry or business: Standard Oil Co. N.J.

FATHER

12. Name: John Rogers

13. Birthplace: Harford County Md.

MOTHER

14. Maiden Name: Mary Finney

15. Birthplace: Harford County Md

16 (a) Informant: MRS. JANE HELEN ROGERS (Wife)

(b) Address: 1701 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 26. 1948 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn Cem.

Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.

(b) Address: Baltimore Md.

19 (a) Date received: OCT 25 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948 at 7 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-23- 1948 and that I last saw him alive on 10-23- 1948

Immediate cause of death: respiratory failure — Duration:

Due to: Carcinomatosis

Due to: carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: Oct. 11, 1948

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Richard T. Griffith Jr. M. D.

Address: John Hopkins Hosp. Date signed: 10/23/48

VS 150

Ast 6

G67949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓

G67949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Clifmont Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joshua Slaysman (JOSHUA FLAHART SLAYSMAN)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-20-3502

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pansy Lee Slaysman

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.) 9-29-75

8. AGE: Years 73 | Months 0 | Days 25 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER — 12. Name Benjamin Slaysman
13. Birthplace Md

MOTHER — 14. Maiden Name Maggie Flahart
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date rec'd by Registrar OCT 25 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1948, at 6:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1948 to 10-23 1948; and that I last saw him alive on 10-23-1948.

Immediate cause of death: Cerebral vascular accident & Thrombosis in left hemiplegia — Duration

Due to: Generalized arteriosclerosis

Due to:

Other Conditions: Diabetes mellitus-mild

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Jackson M. D.
Address The Johns Hopkins Hosp Date signed 10/23/48

VS 150

Huntington Wallace, Md

83a

G67950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G67950 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE FORNOFF

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: William Fornoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 8, 1889

8. AGE: Years 59 | Months 0 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Paul schroll
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Schmidt
15. Birthplace Maryland

16 (a) Informant William E. Fornoff - son
(b) Address 508 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 25 1948 (b) Huntington Willis Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 '48 at 3.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from October 14, 1948 to Oct. 22. 48 and that I last saw her alive on Oct. 22. 1948.

Immediate cause of death: Coronary Artery Occlusion — Duration: ?
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 701 N. Kenwood Ave. Date signed Oct. 23. 48

G67951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G67951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 Waesche St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Waesche St, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Truman J. Blake.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Helen Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 29, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Jr. Blake
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lucinda Snowden
15. Birthplace Md.

16 (a) Informant Helen Blake.
(b) Address 736 Waesche.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Oct 21 1948.
and that I last saw h alive on 19

Immediate cause of death Coronary heart failure — Duration 6 mos
Due to Arteriosclerosis
Due to
Other Conditions Pneumonia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McE. Fennell M. D.
Address 4 W. Eager St. Date signed 10/25/48

VS 150

Every item of information must be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G67952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Lawson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Ailsie Lawson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1894

8. AGE: Years	Months	Days	If less than one day
53	9	25	hr. min.

9. Birthplace Harmony, Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Lawson.
13. Birthplace Harmony Va.

MOTHER
14. Maiden Name Ailsie Lawson
15. Birthplace Harmony Va.

16 (a) Informant Ailsie J. Lawson.
(b) Address 511 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26, 1928 (month) (day) (year)
(c) Cemetery or crematory South Boston, Va
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Lafayette St

19 (a) OCT 25 1928 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1928, at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 19 28 to 10/25 19 28 and that I last saw h alive on 10/25 19 28.

Immediate cause of death — Coronary thrombosis — Duration 5 min.

Due to

Due to

Other Conditions Hypertension and Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ralph W. Lockard, M.D.
Address Date signed 10/26/28

VS 130

667953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 d

Registered No. 667953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Presstman St.
(c) Hospital or institution:

16 07

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Presstman St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ABRAHAM J. ULLMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia Kann Ullman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 23, 1878.

8. AGE: Years	Months	Days	If less than one day
70	7	—	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk:-U.S.Government.
11. Industry or business

FATHER
12. Name Jacob Ullman,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Bettie Milheiser,
15. Birthplace Germany.

16 (a) Informant Mrs. Julia K. Ullman,
(b) Address 3106 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Blair & Sonnenborn & Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Registrar for Williams Bureau

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23rd. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct. 23, 1948.
and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy M. D.
Address 2322 Eutaw Place. Date signed

VS 150

Medical Examiner's Case 2 be Approved by Chief Medical Examiner

A67954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186

Registered No. A67954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St. 105

(c) Hospital or institution: South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 26 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1425 Cherry Street (If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Birthplace Austria

3 (a) FULL NAME FRANK DREXLER

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL 27 1884

8. AGE: Years 64 | Months 5 | Days 26 | If less than one day: hr. min.

9. Birthplace AUSTRIA (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER 12. Name ALEXANDER DREXLER

13. Birthplace AUSTRIA

MOTHER 14. Maiden Name PAULINE TAUBER

15. Birthplace AUSTRIA

16 (a) Informant HUGO DREXLER

(b) Address 1425 CHERRY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location BROOKLYN MD

18 (a) Funeral director Bernard C Hoehle

(b) Address 434 E WEST ST

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1948 at 6 15 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 6 55 PM 10-23 1948 to 15 PM 10-23 1948, and that I last saw h[illegible] alive on 10-23 1948

Immediate cause of death Cerebro Vascular Hemorrhage — Duration 5 days

Due to Hypertensive Arteriosclerotic Cardiovascular Disease — Duration years

Due to —

Other Conditions 1) Far Advanced Pulmonary Tuberculosis 2) Laceration Skin of Occip. Region

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: CERTIFICATION APPROVED BY [illegible], M.D.

Date of autopsy: John R. Brown M.D.

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 10 - 19 1948 at [illegible] M

(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?

(e) Means of injury Fall down Steps following Accident

23. Signature Edward C. Newell M.D.

Address 1213 Light Street Date signed 10-23-48

VS 15

932

167955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 18

Registered No. 167955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave and Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 N. WASHINGTON ST. (If rural, give location)
(e) Citizen of foreign country? N O (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH L SUNSTROM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife WILLIAM T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/61

8. AGE: Years	Months	Days	If less than one day
86	11	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name JAMES J IRWIN
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name JANE WILSON
15. Birthplace BALTIMORE

16 (a) Informant PATIENT
(b) Address 1920 N WASHINGTON ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director C. J. Ferguson & Son
(b) Address 1938 E. Lafayette Ave Funeral Home Baltimore, Md.

19 OCT 25 1948 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1948 at 6 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1948 to 10/22 1948. and that I last saw her alive on 10/21 1948.

Immediate cause of death CEREBRO-VASCULAR ACCIDENT — Duration

CERTIFICATION APPROVED BY Thomas T. Noguchi M.D. CHIEF OR ASST. MEDICAL EXAMINER

Due to HYPERTENSIVE C.V. DISEASE For Wm. Helfrich, M.D.

Due to

Other Conditions FRACT. NECK OF RIGHT FEMUR (Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

Autopsy: Yes Findings Consistent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8/18/48 at M
(c) Where did injury occur? BALTO, 13 (City or town) (County) MD (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury FELL WHILE WALKING

23. Signature Paul G Herold M. D.
Address Maryland Gen Hosp Date signed 10/22/48

93K To be approved by coroner's office

CERTIFICATE CORRECTED 9-1-50

667956 M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1330 Registered No. 667956

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1905

8. AGE: Years	Months	Days	If less than one day
43	2	26	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Edgar Vessells.
13. Birthplace VA.

MOTHER
14. Maiden Name Emma ?
15. Birthplace VA.

16 (a) Informant B.C.H.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Geo. A. Holland
(b) Address 1631 Mount Hill Ave.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1948 at 6:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 8 1948 to Oct. 22 1948 and that I last saw her alive on Oct. 22 1948

Immediate cause of death Uremia

Due to Chronic pyelonephritis

Due to

Other Conditions Significant Hypertension Heart failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Marine M.D.
Address Balto City Hosp's Date signed 10-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 K

Registered No. 67957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. BENTALOU #16 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME Howlett OSBORN / SIMMONS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband/wife IDA H. Simmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 26, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	27	hr. min.

9. Birthplace BALTIMORE Md. (Town, county, and state)
10. Usual Occupation retired MERCHANT MARINE
11. Industry or business Inspector; U.S.C.G.

FATHER
12. Name OSBORN SPRIGG SIMMONS
13. Birthplace BALTIMORE A. A. Co.

MOTHER
14. Maiden Name IDA J. BLAKE
15. Birthplace BALTIMORE Matthews Va.

16 (a) Informant WIFE IDA
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Lurington Nelligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 OCT 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 01 OCT 1948, to 23 OCT 1948, and that I last saw HM alive on 23 OCT 1948.

Immediate cause of death	Duration
CARDIORESPIRATORY FAILURE	6 HOURS
Due to HODGKINS DISEASE	1½ YRS
Due to	
Other Conditions CHRONIC BRONCHITIS HYPERTROPHIC ARTHRITIS ARTERIOSCLEROSIS (Significant conditions contributing to death)	

Date of operation
Major findings of operation:
Co. of autopsy: PERMIT REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen. Hosp. Date signed 23 OCT 48

VS 180

667958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ 667958

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4506 Sorrento Ave.

(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3118 Gwynns Falls Pkwy. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN B. HUDSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma Margaret Hudson nee Hummel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1862

8. AGE: Years 86 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace Providence, R. I. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business A. & P.

FATHER

12. Name Frank Hudson

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary McCusker

15. Birthplace Boston

16 (a) Informant Mr. Henry J. Hudson

(b) Address 3118 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Mills, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948 at 7:15a M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1 1948 to Oct 24 1948, and that I last saw h alive on Oct 23 1948

Immediate cause of death Pulmonary Oedema, Hypostatic pneumonia — Duration

Due to Cerebral arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Robert C Hatch M.

Address 2151 Wilkens Ave Date signed Oct 24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 c Registered No. 667959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
UNION Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 05
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 E. 21st. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACKSON WHEAT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Marie L. Wheat

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chas. O. Wheat
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Edwards
15. Birthplace Va.

16 (a) Informant Nathaniel S. Wheat (Uncle)
(b) Address 912 Keyser Bldg. (F10244)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 217 St. Paul St.

19 (a) OCT 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 23, 1948, at 7:38 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions Ruptured Spleen

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12-5

(a) Date of injury Oct. 22/48 1:50 A.M.
(b) Where did injury occur? Charles & 21st. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by auto

23. Signature Emil H. Rogge M.D. Medical Examiner
Date signed 10/23/48

X

G67960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 77C

Registered No. G67960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 01
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. Lee Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William A. Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th, 1894

8. AGE: Years 54 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace: Maryland
Seaman (Ward, county, and state)

10. Usual Occupation: Arundel Sand Co.

11. Industry or business

FATHER
12. Name: (Unknown) Gregory
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Florence Ferger
(b) Address 309 N. Monastery Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month, day, year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Wm Cook Sons
(b) Address 1217 St Paul St.

19 (a) OCT 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Aorta Aneurism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature: Emil H Rogers, Medical Examiner. M.D.
Date signed 10-25-48

A-667961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24- 1873

8. AGE: Years	Months	Days	If less than one day
75	4	13	hr. min.

9. Birthplace Poughkeepsie, N.Y. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name David Myers
13. Birthplace N.Y.

MOTHER
14. Maiden Name Cecelia Malcox
15. Birthplace N.Y.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St.

18 (a) Funeral director Wm Cook Co.
(b) Address 12 17 St Paul St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7- 1948, at 8,45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1930, to 10-7 1948, and that I last saw h er alive on 10-7 1948.

Immediate cause of death Chronic Nephritis — Duration ?

Due to

Due to

Other Conditions Hypertensive Cardio Vascular Disease — Years

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J Cole MD M. D.

Address 4940 Eastern Ave Date signed 21 Oct 48

VS 150

G67962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94 ✓ Registered No. G67962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 N. Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 24
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Fava

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Maria Fava

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 3rd 188[illegible]

8. AGE: Years 64 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business Vincenzi Macaroni Co.

FATHER
12. Name Joseph Fava
13. Birthplace Italy

MOTHER
14. Maiden Name Joanna M. Gazzo
15. Birthplace Italy

16 (a) Informant Mrs. Maria Fava
(b) Address 2411 N. Pulaski St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10 28 48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 S. Paca St.

19 (a) OCT 25 1948 (b) Funeration Williams, Inc. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1948, at 1 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1948 to Oct 24 1948, and that I last saw h~~im~~ alive on Oct 23 1948.

Immediate cause of death
Cerebral Hemorrhage
Hypertension

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration
2 mos
1 mo
—
—
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible] Vincent

Address 3[illegible] Date signed Oct 25 1948

X

667963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) she said while bringing her upstairs and putting her to bed
(e) Length of stay in Baltimore (yrs., mos., or days) 4 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 501 Wildwood Pk'way (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Jones Annie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife A. Jones.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24 - 1880

8. AGE: Years 68 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Blocher
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dehmm
15. Birthplace Germany

16 (a) Informant Mr A. Jones
(b) Address 501 Wildwood Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo K Berger Jr
(b) Address 1512 Hollins St

19 (a) Date received by registrar OCT 25 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/ 1948, at 10.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1948, to 19 .
and that I last saw her alive on 10/24 1948.

Immediate cause of death Heart failure

Duration

Due to Coronary Thrombosis

Due to Hypertension

Other Conditions CERTIFICATION APPROVED BY

(Include pregnancy within 3 months of death)

Date of operation M. D.

Major findings of operation: CHIEF OR ASST. M. E.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Womack M. D.
Address Bon Secours Hosp. Date signed 10/24/48

X

VS 150

667964 Vol 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 dv

Registered No. 667964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Mount St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Hillery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr) 6-19-07

8. AGE: Years 41 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Hillery
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Clark
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pressman St

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntingtor Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1948, at 4:00 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 10-21 1948 and that I last saw him alive on 10-21 1948.

Immediate cause of death Pulmonary edema. | Duration 5 days.

Due to Congestive heart failure

Due to Hypertensive Sclerotic Heart Disease.

Other Conditions Uremia, anuria.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan Calkins

Address Date signed 10/24/48 M D

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

667965

JL - 123804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 667965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 70 ot

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3109 Leeds St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1900

8. AGE: Years	Months	Days	If less than one day
48	8	14	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jesse Anderson

13. Birthplace ?

MOTHER

14. Maiden Name Sarah Napper

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/26/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md

18 (a) Funeral director George L. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) OCT 25 1948 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1948, at 3.50 PM.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 16. 1948, to Oct. 22 1948, and that I last saw her alive on Oct. 22 1948.

Immediate cause of death Hypertensive cardiovascular disease

Duration 1 Month

Due to Cardiac failure

Due to Hypertension

Duration 3 years +

Other Conditions azotemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature David N Mancini M. D.

Address Balto City Hosp. Date signed 10-25-48

0679966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 0679966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saint Joseph's Hosp/
(c) Hospital or institution: 8.06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Hines Jr.

3 (b) If veteran, name war: W.W. #I

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/1893

8. AGE: Years 55 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business A. Hoen And Co.

FATHER
12. Name Frank Hines Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Pauline C. Oppel
15. Birthplace Md.

16 (a) Informant Family
(b) Address 3709 Fifth Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) OCT 26 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/1948, at 8 26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-1948 to 10/23 1948, and that I last saw h— alive on 10/21 1948.

Immediate cause of death	Duration
Coronary Vascular disease	4 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Weiss, M.D.
Address 1927 E. North Ave. Date signed 10-26-48

VS 150

67967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 N Registered No. 67967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Reisner Elizabeth M. Reisner

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: W. Francis

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Mar. 7 1885

8. AGE: Years: 63 Months: 5 Days: 16 If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation:

11. Industry or business: At Home

FATHER
12. Name: Henry J. Freund
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine R. Reichert
15. Birthplace: Balto.

16 (a) Informant: W. Francis Reisner
(b) Address: 423 Chapel Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 27 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4600 Belair Rd

18 (a) Funeral director: Dippel Bros.
(b) Address: 7610 Belair Rd

19 (a) Oct 25 1948 (b) Filed by registrar: Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1948, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1948, to Oct. 25 1948, and that I last saw h alive on 19

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral Infarct.

Due to: Brain Cytoplasma

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. C. Hamlin, M.D.
Address: University Hospital Date signed: Oct 27 M. D.

VS 150

G67968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67968
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 William St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 William St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Eckhardt

3 (b) If veteran, name war: 0000

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Howard Eckhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1876

8. AGE: Years	Months	Days	If less than one day
72	3	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Lilly
13. Birthplace N. J.

MOTHER
14. Maiden Name Sarah E. Fortner
15. Birthplace Md.

16 (a) Informant Mr. Howard Eckhardt
(b) Address 1025 William St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A.Co., Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 OCT 25 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948 at 12.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 19 Oct 24 19 48, and that I last saw her alive on Oct 23 19 48.

Immediate cause of death	Duration
Pernicious anemia (Right hemiplegia)	1 month
Due to Stag Horn Kidney	2 years
Due to Stone	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 122 E. Chase St. Date signed 10 Oct 48

VS 150

667969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 L

667969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3841 Clifton Ave.
(c) Hospital or institution: West Balto. Gen. Hosp. (OOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-09
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3841 Clifton Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul William Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-6037

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rose C. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years 68 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired - Civil Service

11. Industry or business

FATHER
12. Name Karl Thomas
13. Birthplace Germany

MOTHER
14. Maiden Name Lena
15. Birthplace Germany

16 (a) Informant Mrs. Rose C. Thomas
(b) Address 3841 Clifton Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct. 1948 at 3 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing Injury of Chest, Bilateral

Due to Fall

Other Conditions Cataracts, bilateral Both ms Hypostatic Pneumonia (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 23 Oct 48 at 2:30 P. M.
(b) Where did injury occur? Clifton Ave. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work?
(d) Means of injury Fall from bridge

23. Signature Wm. H. Hammond, Jr. M.D. Medical Examiner.
Date signed 23 Oct. 48

VS 151

G67970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G67970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 154 - Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State ... County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 - Pennsylvania Ave
(If rural give locality)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fletcher

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr) Feb. ? 1893

8. AGE: Years 55 | Months 8 | Days ? | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name Sally Lounck
15. Birthplace Va

16 (a) Informant Fletcher Lewis
(b) Address 953 - Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Calvary

18 (a) Funeral director A. A. Whitehead
(b) Address 918 - Druid Hill Ave.

19 (a) 10-25-1948 (Date rec'd by registrar) Tomlinson Wallace, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1948 to 10-22-1948, and that I last saw her alive on 10-22-1948

Immediate cause of death Mitral insufficiency
pulmonary edema

Duration

Due to Essential hypertension & hypertensive cardio-renal disease

Due to

Other Conditions Pneumonia, bilateral
TB Pulmonary

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address ... Date signed 10-25-48 M. D.

VS 133

X

G67971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G67971
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROGER LAWRENCE THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Myrtle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ?, 1904

8. AGE: Years	Months	Days	If less than one day
44	9	-	hr. min

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Helper on truck

11. Industry or business

FATHER
12. Name ? Thomas
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Annells
15. Birthplace Washington, D.C.

16 (a) Informant: Myrtle Thomas
(b) Address 1326 McCulloh St.

17 (a) Burial (b) Date thereof 10-27-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Mount Calvary

18 (a) Funeral director A. Halsteadt
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] (Signature of registrar) Edrington Williams, M.D.

VS (51)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, at 7.20 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Congestive Heart Failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? (While at work)
(d) Means of injury

23. Signature Earl L. Royster M.D.
Medical Examiner
Date signed October 24, 1948

X

G67972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G67972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1139 N. Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA REVELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-1861

8. AGE: Years	Months	Days	If less than one day
86	10	10	hr. min.

9. Birthplace Exmure, Virginia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Custus Revell
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosa James
15. Birthplace Virginia

16 (a) Informant Anna Revell
(b) Address 1139 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave.

19 (Date rec'd by registrar) OCT 25 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 12.01 AM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec- thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 10/22/48

VS 151

G67973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 S. Oldham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Oldham (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Raymond Clay Yost

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 214-01-7373

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 8, 1909

8. AGE: Years	Months	Days	If less than one day
39	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter work
11. Industry or business Textile Equipment Mfg. Co.

FATHER
12. Name John Yost
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie Yaeger
15. Birthplace Baltimore

16 (a) Informant Lewis Yost
(b) Address 615 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location 6 a. Mt. Car.

18 (a) Funeral director Thos. A. Connelly
(b) Address 415 Eastern Ave. East Huntington Williams, Md.

25 1948 Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Oct. 1948, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Oct. 1948, to 22 Oct. 1948 and that I last saw him alive on 22 Oct. 1948.

Immediate cause of death: Coronary Occlusion — Duration 2 hrs.
Due to
Due to
Other Condition

CERTIFICATION APPROVED BY
J. Thomas, M.D.
for John R. Davis M.D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Tracy Mowen M. D.
Address 1601-D Pickenbacker Rd Date signed 9/24/48

Essex Md.

VS 150

X

G67974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55d

Registered No. 23974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution: Elmhurst Nursing Home 1703

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2627 Calvert St
(If rural give location)

(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME William Brandt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE:	Years	Months	Days	If less than one day
	84	—	—	hr. min.

9. Birthplace UNKNOWN.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant DAVID MELNAUSER

(b) Address 610 LENNOX ST. BALTO. 17

17 (a) CREMATION (b) Date thereof OCT. 25, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory GREENMOUNT

Location GREENMOUNT AND NORTH AVE.

18 (a) Funeral director Walter Burke Bradley

(b) Address 1922 W. North Ave.

(Date rec'd by registrar) OCT 26 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 October 1948, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1948 to Oct. 23 1948. and that I last saw him alive on Oct. 23 1948.

Immediate cause of death	Duration
generalized Carcinomatosis.	
Due to CA - nose - began - with extensive destruction	
Due to nose & adjacent sinuses	
Other Conditions Destruction present when entered Elmhurst Nursing Home	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: Hemorrhagic Christian Screen

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis Epaulo

Address 1709 Eutaw Pl. Date signed Oct 25 1948
M. D.

VS 150

X

G67975 12-48-1879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1195 Registered No. G67975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1720 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles Shifflet
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race white
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-27-48
8. AGE: Years | Months 2 | Days 7 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business
FATHER 12. Name Noah Shifflet
13. Birthplace Va.
MOTHER 14. Maiden Name Ruby Dykes
15. Birthplace Va.
16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gerson Hill Road
18 (a) Funeral director Lilly & Zeh-Lahr
(b) Address 403 W. Fayette St
19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Station, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948, at 9:15 a M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/24 1948, and that I last saw him alive on 10/24 1948

Immediate cause of death	Duration
Intestinal Hemorrhage	
Due to Diarrhea ? Dysentery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John L. Ryan M. D.
Address J.H.H. Date signed

VS 150

X

G67976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1175

Registered No. G67976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Highland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs BESSIE-E. NELSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Bernard Nelson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 5-10-93

8. AGE: Years	Months	Days	If less than one day
55	5	15	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James H Bradley
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lilly Matthews
15. Birthplace W-Va.

16 (a) Informant Husband
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto

18 (a) Funeral director Jos J Stevenson
(b) Address 3021 Kentucky ave

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1948, at 2:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28-1948 to 10-25-1948, and that I last saw her alive on 10-25-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Gastric hemorrhage	
Due to Duodenal ulcer	? months
Cancer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-16-48
Major findings of operation: Cancer duodenal ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn E. Jones M.D.
Address Mercy Hospital Date signed 10-26-48

VS 150

X

G67977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G67977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Blanche Gore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward Gore
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	17	hr. min.

9. Birthplace Philadelphia, PA. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John C. Hook
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Hutton Hooton
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Carroll A. Hook
(b) Address 5008 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilkes Lamoreux
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) (b) Interment Not Necessary

OCT 29 1948

VR 196

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948, at 12:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1948 to Oct. 24 1948, and that I last saw her alive on Oct. 24 1948.

Immediate cause of death	Duration
Heart Failure	
Due to Myocardial Infarct	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Post. Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Chorley Decker M. D.
Address Women's Hospital Date signed 10-28-48

X

667978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C

Registered No. 667978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4700 Harford Road

(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 710 East Biddle St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Leland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thos Leland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1878

8. AGE: Years	Months	Days	If less than one day
70	9	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Daniel O'Sullivan

13. Birthplace Ireland

MOTHER

14. Maiden Name Elizabeth McAlister

15. Birthplace Ireland

16 (a) Informant Bernard O'Sullivan

(b) Address 710 East Biddle St

17 (a) Burial (b) Date thereof Oct. 26, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St

19 (Date rec'd by registrar) OCT 25 1948 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct. 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 1948 and that I last saw her alive on 20 Oct. 1948.

Immediate cause of death: Chronic Hypertrophic Arthritis — Duration: 20 yrs.

Due to

Due to

Other Conditions Arteriosclerotic Cardio Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm. A. Kamman, J.

Address 5015 Sheridan Ave Date signed 25 Oct. 48

G67979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. G67979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 01
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Schaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Jannie Burpees
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr) June 6 1872

8. AGE: Years	Months	Days	If less than one day
76	4	17	hr. min.

9. Birthplace Dellan Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Adam Schaffer
13. Birthplace

MOTHER 14. Maiden Name Kath. Hooper
15. Birthplace

16 (a) Informant Ella Sines 7 Fr Pa
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Windefield
(b) Address 900 East Biddle St.

19 (a) Oct 25 1948 (Date received by local registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1948 at 4-a. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1 1948, to Oct 23 1948, and that I last saw him alive on Oct 22 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Hypertensive Cardio	
Due to Vascular Disease	1 yr
Other Conditions Arteio Sclerosis	10 Yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature E Gale Hall
Address 1631 E North Ave Date signed 10/23/48 (M. D.)

VS 150

667980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 H

Registered No. 667980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 21 N Carey St
(a) Baltimore City, Maryland
(b) Street address 444 Monroe St
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 444 Monroe St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aileen Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
33	0	1		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Robert Carr
13. Birthplace Pa

MOTHER
14. Maiden Name Lillie Clark
15. Birthplace Maryland

16 (a) Informant Robert Carr
(b) Address 632 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Wm P Jackson
(b) Address 916 Penna Ave

19 [redacted] 25 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/48 19 at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3/48 to 10/21/48 and that I last saw h[illegible] alive on 10/20/48

Immediate cause of death: Intestinal Obstruction — Duration: 1 week

Due to: Cancer uterus & metastases — Duration: unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter J Bowen

Address 402 Edmondson Ave Date signed 10/27/48

VS 193

X

Dr. Wm. Hospital
1700 Eutaw Pl. Baltimore Md.

G67981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertie A. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-05-5738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Arthur Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	17	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business New Vogue Cleaners

FATHER
12. Name L. A. Hall
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Ruth Craighead
(b) Address 1700 Eutaw Place

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Sherwood
Location Roanoke, Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

OCT 25 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 4:30 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948 to Oct 25 1948 and that I last saw him alive on Oct 22 1948

Immediate cause of death	Duration
Carcinoma of Intestinal Tract	one year
Due to Carcinoma	
Other Conditions Carcinoma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Wm Cook M. D.
Address 1217 Eutaw Pl. Date signed 10/25/48

VS 150

T 467982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 467982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Woodbine RURAL
(If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Fink Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 48

8. AGE: Years | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Poplar Spring Md
(Town, county and state)

10. Usual Occupation C

11. Industry or business

FATHER
12. Name John J. Fink
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna Belli
15. Birthplace Balto

16 (a) Informant John D. Fink
(b) Address Kay. Carr Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Relair Md

18 (a) Funeral director Ly McDaniel
(b) Address Ell N Ave

19 (a) OCT 25 1948 (Date rec'd by registrar) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948, at 11:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-11 1948 to 10-24 1948, and that I last saw him alive on 10-24 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-14-48

Major findings of operation: Cholycystotomy Duodenostomy done

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Holloway M. D.
Address University Hospital Date signed 10-24-48

VS 150

G67983
ES-78979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0 13 G67983 Registered No.

LEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Salvation Army
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lurz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife Antonia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	0	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Lurz
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhimina Schulten
15. Birthplace Holland

16 (a) informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Belford Rd.

19 (a) OCT 25 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948 at 9:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-5-43 1943 to 10-22 1948 and that I last saw him alive on 10-22 1948

Immediate cause of death: Hemorrhage from lungs — Duration: 2 days
Due to: For advanced bilateral pulmonary tuberculosis — Duration: 2 yrs (?)
Due to:
Other Conditions: Generalized arteriosclerosis — Duration: yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M.D.
Address Baltimore City Hosp Date signed 10-24-48

YS 150

X

G67984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 G67984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Bayonne Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence B. Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife James L. Crawford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1883

8. AGE: Years 65 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Fredericksburg, Va. (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Henderson

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. James L. Cannon

(b) Address 3711 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)

(c) Cemetery or crematory Maryland Pk

Location Balto

18 (a) Funeral director J. J. Luck

(b) Address 5305 Harford Rd.

OCT 25 1948 (Date rec'd by registrar) (b) Interment, Removal, Cremation

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 OCT 1948 at 9.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 OCT 1948 to 23 OCT 1948, and that I last saw h alive on 19

Immediate cause of death CARDIORESPIRATORY FAILURE — Duration 24 hours

Due to PRIMARY ATYPICAL PNEUMONIA — 6 DAYS

Due to

Other Conditions DIABETES MELLITUS CORONARY SCLEROSIS

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation AUTOPSY PLEURAL EFFUSION FIBRINOUS PERICARDITIS CORONARY SCLEROSIS

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald L. England M. D.

Address Maryland Gen. Hosp. Date signed 23 Oct 48

109a

VS 150

G67985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G67985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5719 Ridgedale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 ---
(e) Length of stay in Baltimore (yrs., mos., or days) 88 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5719 Ridgedale Road (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Annie B. Melis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) Jan. 30, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	25	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Martin Melis
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalena Bachner
15. Birthplace Germany

16 (a) Informant Mrs. Stanley Belcher
(b) Address 5719 Ridgedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Weaver and Son
(b) Address 805 N. Calvert Street

OCT 25 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948, to Oct 24 1948, and that I last saw her alive on Oct 24 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 mo.
Due to Cerebral Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel H. Belcher M. D.
Address 5611 Timber Rd Date signed 10-27-48

G67986

ES-123667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

956 G67986 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: Balto. city hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2567 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE C. JEFFREY

3 (b) If veteran, name war ******

3 (c) Social Security Account No. ********

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leroy Jeffrey

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr) Jan. 11, 1900

8. AGE: Years 48 | Months 10 | Days 12 | If less than one day ******** min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation housewife at

11. Industry or business home

FATHER
12. Name George Whatmough
13. Birthplace England

MOTHER
14. Maiden Name Lilly Lloyd
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 26/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 13000 EUTAW PLACE..17

OCT 25 1948 (a) (b) (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948 to 10-22 1948.
and that I last saw her alive on 10-22 1948.

Immediate cause of death Cardiac failure — Duration 6 mos

Due to ? Rheumatic heart Dis — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Rechtold M. D.
Address Balto City Hosp. Date signed 10-25-48

GG7987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GG7987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 406 EDGEWOOD STREET

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 310 N. Pulaski Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country NO.

3 (a) FULL NAME JAMES H. BROWN

3 (b) If veteran, name war ******

3 (c) Social Security Account No. ******

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sarah Brown

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) Dec. 24-1868

8. AGE: Years	Months	Days	If less than one day
79.	10	--	hr. min.

9. Birthplace Harrington Delaware (Town, county, and state)

10. Usual Occupation Motorman - Retired

11. Industry or business Baltimore Transit Co.

FATHER
12. Name John Henry Brown
13. Birthplace Delaware

MOTHER
14. Maiden Name Clemintine Harrington
15. Birthplace Delaware

16 (a) Informant Mrs. Olive B. Griffiss

(b) Address 406 Edgewood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26/48 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Dorsey Maryland

18 (a) Funeral director F. B. Wippert & Son

(b) Address 1300 Eutaw Place...17

19 (a) OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, at 2 15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Oct 23 1948. and that I last saw him alive on Oct 23 1948.

Immediate cause of death	Duration
Cardio vascular - nephritis	several yrs.
Due to Uremia -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W B Carman M.D.

Address 2200 Guilford Blvd Date signed 10-25-48

VS 150

G67988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No.: Route 5 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: EARL "C" MORTON

3 (b) If veteran, name war: WW I & WW 2

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther Howard Morton

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1894

8. AGE: Years: 54 | Months: 2 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Jacksonville NC (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Coast Guard

FATHER
12. Name: Leonard Morton
13. Birthplace: NC

MOTHER
14. Maiden Name: Emma Mason
15. Birthplace: NC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 28-48 (month) (day) (year)
(c) Cemetery or crematory: Meadow Branch
Location: Carroll Co

18 (a) Funeral director: J Bankard & Son
(b) Address: Westminster Md

19 (a) Oct 28 1948 (b) Filed by registrar: Lenton for Williams M.D. Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 1948, at 4:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1948 to Oct. 25 1948, and that I last saw him alive on Oct. 25 1948.

Immediate cause of death: Ruptured jejunal diverticulum and peritonitis — Duration: 18 hrs.

Due to:

Due to:

Other Conditions: (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Jr. Surgeon
Address: Clinical Director Date signed: 10/25/48 M. D.

667989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 93d

667989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Lerman Hill Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Bulko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Florence Edith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 2, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Painter and Paperhanger
11. Industry or business Self employed

FATHER
12. Name Andrew Bulko
13. Birthplace —

MOTHER
14. Maiden Name Mary —
15. Birthplace —

16 (a) Informant Mrs. Florence Bulko.
(b) Address 207 Herman Hill Rd. Balto 22, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Shangokin, Pa.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948. at 5:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from October 23 1948 to Oct 25 1948 and that I last saw him alive on Oct 23 1948

Immediate cause of death Subarachnoid Hemorrhage — Duration 7 hrs
Due to Hypertensive Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Pearce Jr. M.D.
Address St. Joseph's Hosp. Date signed 10/25/48

X

667990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

667990 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Dillon Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N/K
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Dillon Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANNA DOBIHAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John Dobihal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 29th, 1885

8. AGE: Years	Months	Days	If less than one day
62	8		hr. min.

9. Birthplace unknown (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Kahl
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. John Dobihal
(b) Address Greenhaven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 26 1948 (Filed record by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Oct 23 1948, and that I last saw h[illegible] alive on Oct 22 1948.

Immediate cause of death	Duration
Generalized Arteriosclerosis	
Generalized Dystrophia adiposa	
Due to Chronic Myocarditis	Nov 1945
Myocardial Failure	Oct 23/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Ed Schimunek M. D.
Address 942 S. Eastlake Date signed 10-25-48

X

G67991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Rayner Ave.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife William R. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1893

8. AGE: Years	Months	Days	If less than one day
55	9	29	hr. min.

9. Birthplace Fredonia, N. Y. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name August T. Groll
13. Birthplace Fredonia, N. Y.

MOTHER
14. Maiden Name Augusta Hildebrant
15. Birthplace Fredonia, N. Y.

16 (a) Informant William R. Thomas
(b) Address R. F. D. Cambridge, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Spedden
Location R.F.D. Cambridge, Md.

18 (a) Funeral director Granville LeCompte
(b) Address Cambridge, Maryland.

19 (a) OCT 26 1948 (Date rec'd by registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1948 to Oct 25 1948, and that I last saw h-er alive on Oct 25 1948.

Immediate cause of death
Cardiorespiratory arrest
Due to Brain Tumor

Duration: 3 wks (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Oct 23, 1948
Major findings of operation: Same as above
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Silverstein M. D.
Address West Balto Gen. Hosp. Date signed 10/25/48

VS 150

667992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

667992
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel H. Hamburger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband or wife Emma R. Hamburger nee Stumpner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1868

8. AGE: Years 80 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bottle industry

FATHER
12. Name John Hamburger
13. Birthplace U. S.

MOTHER
14. Maiden Name Fanny Karman
15. Birthplace U. S.

16 (a) Informant Mrs Cora Shaffer
(b) Address 1920 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western
Location Edmondson Ave. Balto., Md.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 26 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 166

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 11:40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1948 to Oct 24 1948; and that I last saw him alive on Oct 24 1948.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Benjamin Haden M. D.
Address 2306 Eutaw Pl Date signed 10-26-48

67993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5-a

67993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2436 N Charles St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2436 N Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Cary Pearson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-03-0802

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 30 1880

8. AGE: Years 68 | Months 0 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Elite Restaurant (9 yrs)

FATHER
12. Name Thomas G. Pearson
13. Birthplace probably Balto Md.

MOTHER
14. Maiden Name Mary Russell
15. Birthplace probably Balto Md.

16 (a) Informant Miss Avondale N. Gordon (friend)
(b) Address 2436 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Stuart Mc Guire Co.
(b) Address 108 W Mt Royal Ave

19 (a) OCT 26 1948 (Date rec'd by Registrar) (b) Permit for Burial issued by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Oct 24 1948 and that I last saw h[illegible] alive on Oct 23 1948

Immediate cause of death: Carcinoma of Pancreas Metastatic

Due to: ~~Secondary~~ Carcinoma of Liver Generalized metastasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration: Known 3 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Clough

Address 24 E. Eager Date signed Oct 25

VS 150

667994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Cairo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Cairo St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Georgie Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30. 1892

8. **AGE:** Years 56 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Blake

13. Birthplace unknown

MOTHER 14. Maiden Name Margaret Blake

15. Birthplace G. A. Co. Md

16 (a) Informant Eugene Blake

(b) Address 25 K. St. N.E. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Betsley ave

19 OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 48 19 at 1 00 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 16 48 19 to Oct 23 48 19, and that I last saw h alive on Oct 23 48

Immediate cause of death	Duration
Acute Myocarditis	1 week
Due to Mass up abdomen	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen Foster M.D.

Address 1411 Cairo St Date signed Oct 25 48

VS 150

G67995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G67995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6681

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	widowed

6 (b) Name of husband or wife Adele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	4	8		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes Williams
15. Birthplace Maryland

16 (a) Informant Ethel Scott
(b) Address 122 N. Fremonth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month, day, year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave.

19 OCT 26 1948 (b) Huntington Williams, M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948, at 11.30 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify in each case)
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed October 24, 1948

VS 151

G67996

478742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)

(d) Street No. 5626 Lock Raven, Blvd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Isaac Norris, Sr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edna V. Norris

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 18, 1880

8. AGE: Years 68 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)

10. Usual Occupation Retired - Vice President

11. Industry or business Bradford Fed. Sav. & Loan Asso.

FATHER

12. Name Francis Norris

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Elizabeth Stevens

15. Birthplace Balto. Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 - 1948 at 11:50 PM ~~12:15 AM~~

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 24 1948 to Oct. 24 1948 and that I last saw him alive on Oct. 24 1948

Immediate cause of death: myocardial infarction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. S. Tickner

Address Johns Hopkins Date signed 10/25/48 M. D.

X

G67997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G67997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden Ave & Madison St
(c) Hospital or institution: Maryland Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 dys
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 N. BENTALOU ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HAMILTON W ROUSE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-26-5228

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: EDNA E. ROUSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1894

8. AGE: Years 54 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace: BALTIMORE (Town, county, and state)

10. Usual Occupation: Coal & Fuel Dealer

11. Industry or business: Benson Fuel Corp.

FATHER
12. Name: FRANCIS W. ROUSE
13. Birthplace: BALTIMORE

MOTHER
14. Maiden Name: HANNAH JANE BRUNNER
15. Birthplace: BALTIMORE

16 (a) Informant: EDNA E. ROUSE (WIFE)
(b) Address: 1441 N. BENTALOU ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (d) OCT 26 1948 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct 1948, at 6 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/25 1948, and that I last saw h[illegible] alive on 10/25 1948.

Immediate cause of death: CARCINOMATOSIS OF LIVER — Duration

Due to

Due to

Other Conditions: CIRRHOSIS OF LIVER
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: CARCINOMA OF LIVER

of autopsy: CARCINOMA OF LIVER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. C. Crawford M. D.
Address: Md. Gen'l Hosp Date signed 10/25/48

VS 150

667998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2403 W. Lanvale St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2403 W. Lanvale St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM BOEHM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Agnes Boehm nee Sieber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 28, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	26	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farmer

FATHER

12. Name Unknown

13. Birthplace Czechoslovakia

MOTHER

14. Maiden Name Unknown

15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Anna Bailey

(b) Address 2403 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948 at 1:50p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17, 1948 to Oct 24 1948, and that I last saw h[illegible] alive on Oct 23 1948

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George E. Shannon M.D.

Address 820 Medical Arts Bldg Date signed 10/26/48

VS 150

X

66999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 66999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4803 York road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4803 York road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE M. MESKILL

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Edmund J. Meskill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1874

8. AGE: Years	Months	Days	If less than one day
74	5	2	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Martin Conner
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Murray
15. Birthplace Ireland

16 (a) Informant Edmund Meskill
(b) Address 4803 York road

17 (a) Burial (b) Date thereof 10/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Funeral
(b) Address 118 N. Mt. Prospect Ave

19 (a) OCT 26 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948 19 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 24 1948, and that I last saw her alive on Oct 24 1948.

Immediate cause of death Hypertensive Cardio Vascular disease

Due to

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Davey M. D.
Address 1544 W. Fort Ave Date signed 10/25/48

13d

G63000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G63000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Georgina Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Julius Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 - 1867

8. AGE: Years	Months	Days	If less than one day
81	4	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Peter C. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Hoenicke
15. Birthplace Germany

16 (a) Informant Mrs. Edna S. Meyer
(b) Address 2736 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Chas. P. Towell
(b) Address 2427 Edmondson Ave

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1948, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to Oct 24 1948. and that I last saw h[illegible] alive on Oct 24 1948.

Immediate cause of death	Duration
Coronary occlusion	
Myocardial failure	
Due to Arteriosclerosis	
Cardio vascular disease	
Due to Senility	
Other Conditions Bronchitis	
Emphysema, congestion of lungs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1801 Hayward Rd Date signed 10/25/48

V S 150

8001

BC-48-25207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G68001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 South Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen Patrick Mills WILLS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1948

8. AGE: Years	Months	Days	If less than one day
		5-4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Owen Patrick Wills
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annette Marie Muir
15. Birthplace Ellwood City, Pa.

16 (a) Informant Mother
(b) Address Same as above

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 26 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD.

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

19 OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25, 1948, at 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948.

Immediate cause of death	Duration
Anoxia	
Due to Respiratory Failure	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Baldi M. D.
Address University Hospital Date signed 10-25-48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Be sure to give correct age is especially important.

VS 150

G68002

BALTIMORE CITY HEALTH DEPARTMENT ✓ 54b Registered No. G68002

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315-S. Caton Ave.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 315-S. Caton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY T. MARSH.

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Sadie M. Marsh.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July. 11-1903.

8. AGE: Years 45 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Farmer -

11. Industry or business Quality Beef Co.

FATHER
12. Name Harry T. Marsh.
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Bessie Crapp.
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Sadie M. Marsh
(b) Address 315-S. Caton Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 27-'48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 - Frederick Ave.

19 (Date rec'd by registrar) OCT 26 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

29. DATE OF DEATH October, 24 1948, at 10.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1948 to Oct 24 1948. and that I last saw him alive on Oct 28 1948.

Immediate cause of death Tumor of Brain (Glioma)

Due to Unknown

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2451 Wilkens Ave Date signed 10/25/48

V S 150

G68003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Taney Rd.
(c) Hospital or institution: 4 or

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Greene Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelina Marsiglia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Angelo Santo
13. Birthplace Italy

MOTHER
14. Maiden Name Cimino
15. Birthplace Italy

16 (a) Informant Anthony Marsiglia
(b) Address

17 (a) Burial (b) Date thereof Oct. 27-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4430 Old Frederick Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Guilford Ave.

OCT 26 1948 (a) 26 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948 at 5 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from September 22 1948 to October 25 1948 and that I last saw her alive on Oct 22 1948:

Immediate cause of death Bronchopneumonia — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Siscanke, M.D.
Address 1429 W Fayette St Date signed 10/25/48

G68004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68004 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Provident Hosp.
(c) Hospital or institution: 1517 Division St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Pinder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1875

8. AGE: Years: 73 | Months: 8 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Centerville, Md. (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business

FATHER — 12. Name: Edward Pinder
13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Mary A. ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice A. Pinder
(b) Address: 1208 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Zion
Location: Baltimore, Md.

18 (a) Funeral director: Thos. George J. A. Gibson Sr.
(b) Address: 1735 Druid Hill Ave.

19 (a) Oct 26 1948 (Date received by Local Registrar) (b) Huntington (Baltimore), Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/48 19 . at 9:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27/48 to 10/24/48 and that I last saw him alive on 10/24/48

Immediate cause of death: Carcinoma of Stomach
Due to: & metastasis to liver, Pancreas & regional lymph nodes.
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation 10/2/48
Major findings of operation same as above
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H Adelcone M. D.
Address: 1131 Harlem Ave. Date signed: 10/25/48

VS 150

G68005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. G68005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 5 0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hillen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PETER JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1893

8. AGE: Years: 55 | Months: 8 | Days: 16 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Fowlkner
15. Birthplace Va.

16 (a) Informant Hayward Johnson
(b) Address Virgilina Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Robt. A. Elliott & Daugh.
(b) Address 1129 N. Caroline St.

19 (a) OCT 26 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Ing. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weaver M.D. Medical Examiner.
Date signed 10/22/48

VS 151

X

G68006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77C

Registered No. G68006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. McClain.

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1920

8. AGE: Years 28 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Zorah ?
15. Birthplace North Carolina

16 (a) Informant Wilma Breeden
(b) Address 1226 N. Caroline St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (date) (year)
(c) Cemetery or crematory
Location Dunn, N. Carolina

18 (a) Funeral director Mrs. Robt. A. Elliott & Dt.
(b) Address 1129 N. Caroline St.

19 OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948 10.50 P M

21. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema
Cerebral edema

Due to Acute alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C. Rose M.D. Medical Examiner.
Date signed October 24, 1948

VS 151

G68007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No. G68007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1834 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Flickinger Zentz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Irma H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1897

8. AGE: Years 51 | Months 9 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Ice Co.

11. Industry or business

FATHER
12. Name Franklin Zentz
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Flickinger
15. Birthplace Md.

16 (a) Informant Mrs. Irma Zentz
(b) Address 1834 N. Duncan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto

18 (a) Funeral director L. J. Leuck
(b) Address 5305 Harford Rd.

19 OCT 26 1948 (Date rec'd by registrar) (b) Burlington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct. 1948 at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 25 Oct. 48

Dr. Gordy
668008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
83a

Registered No. 668008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4900 Walther Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Walther Blvd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary C. Kratz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad Kratz
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Bing
15. Birthplace Md.

16 (a) Informant Mrs. Marie Northrup
(b) Address 4900 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Jeruselem Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 26 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 24 1948.
and that I last saw her alive on Oct 15 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 18 days
Due to Hypertension — 10 years
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: no
of autopsy: no

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury none

23. Signature L. F. Gordy M.D.
Address 5106 Harford Road Date signed 10/25/48

VS 199

G68003 Hospital Dispersal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G68005

Prem. 2 Co 48-23024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 605 N. Pulaski St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Seward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-21-48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Irving Seward

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 OCT 26 1948 Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948, to 10-22 1948, and that I last saw him alive on 10-22 1948.

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. C. Irving M. D.

Address Johns Hopkins Hosp Date signed 10-23-48

G68010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 65B

G68010
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS MARY AGNES BUNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Albert T. Bunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1881

8. AGE: Years	Months	Days	If less than one day
67	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name James Cleary
13. Birthplace —

MOTHER
14. Maiden Name Anna Mara
15. Birthplace —

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND.

19 (a) [illegible] (b) [illegible] (c) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mond. Oct. 25 1948, at 1 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 25 1948, and that I last saw her alive on Oct 25 1948.

Immediate cause of death	Duration
Peripheral vascular collapse	2 hrs
Due to Septicemia with probable hemorrhage	
Due to arts adrenals	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Bowen M D
Address Mercy Hospital Date signed 10-25-48

VS 150

G68011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 F

Registered No. G68011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univeristy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne A
(c) City or town Dorsey, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Ohio Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRMA M. LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John G. ee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1918

8. AGE: Years 30 | Months 5 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace: Dorsey, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Claude F. Dunkerly
13. Birthplace: Baltimore Co., Md.

MOTHER
14. Maiden Name: Mary E. Litchfield
15. Birthplace: Baltimore Co., Md.

16 (a) Informant: Mr. Claude F. Dunkerly
(b) Address: Ohio Avenue, Dorsey, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1028-48 (month) (day) (year)
(c) Cemetery or crematory: Zion Cemetery
Location: Dorsey, Maryland

18 (a) Funeral director: John J. Cowan & Son
(b) Address: 901-03 Hollins Street

19 (a) OCT 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry Partial autopsy. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-48 at Approx. 6:15 P. M.
(b) Where did injury occur? Dorsey, Maryland
(c) Did injury occur at home, on farm, in Industrial place, in public place? R. R. Prop. While at work? No
(d) Means of injury Jumped in front of train

23. Signature Medical Examiner. M.D.
Date signed 10-26-48

VS 151

668012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 E CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE.
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town).
(d) Street No. 3008 E KESWICK RD. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EARNEST CLAGGETT.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MINNIE CLAGGETT
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr) NOV 8 1870

8. AGE: Years	Months	Days	If less than one day
77	11	15	hr. min.

9. Birthplace MARYLAND. (Town, county, and state)
10. Usual Occupation GARDNER.
11. Industry or business

FATHER
12. Name LUTHER CLAGGETT.
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JOHANNA WATKINS
15 Birthplace MARYLAND.

16 (a) Informant MILDRED STINCHCUM
(b) Address 927 HOLLEN RD, BALT Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-1948 (month) (day) (year)
(c) Cemetery or crematory Bethesda Location Brookeville, Montgomery Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 OCT 26 1948 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 24 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 23 1948 to OCT 24 1948, and that I last saw him alive on OCT 24 1948.

Immediate cause of death Cerebro vascular Accident — Duration
Due to Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions Nephrosclerosis, chronic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William E. Brown M. D.
Address Union Memorial Hosp Date signed 10-24-48

VS 150

668013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Stricker St
(c) Hospital or institution: 1901
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Edna Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fimal.

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Pickens Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1885

8. AGE: Years 63 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Edgefield, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aaron Mathis
13. Birthplace Edgefield, S.C.

MOTHER
14. Maiden Name Rose
15 Birthplace Edgefield, S.C.

16 (a) Informant Lucy Hutto
(b) Address 411 N. Stricker.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) OCT 26 1948 (Date rec'd by registrar) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1948 at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1948 to Oct 22 1948, and that I last saw h[illegible] alive on Sept 18 1948.

Immediate cause of death Valvular Heart Disease — Duration 1

Due to Hypertension — 3

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard, M.D.
Address 904 N Fulton Ave Date signed 10/23/48

VS 180

G68014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68014 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 872 W. Fayette St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Same

(If outside city or town limits, write RURAL and give town)

(d) Street No. 872 W. Fayette St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Winder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura Winder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years: 71 Months: 8 Days: 20 If less than one day: hr. min.

9. Birthplace Morgan Mo. (Town, county, and state)

10. Usual Occupation House man

11. Industry or business

FATHER 12. Name George A. Winder

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Kelly

15. Birthplace Md.

16. (a) Informant Laura Winder

(b) Address 872 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 27, 1948. (month) (day) (year)

(c) Cemetery or crematory Loudon Park Memorial

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) OCT 26 1948 (Date received by Registrar) Mrs Katie R. Williams (Funeral director)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to Oct 22 1948

and that I last saw [illegible] alive on Oct 22 1948.

Immediate cause of death: Chr. Nephritis

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed Oct 26 48

VS 150

G68015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G68015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Harris

3 (b) If veteran, name war World War II

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Mary Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6, 1917

8. AGE: Years 30 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Augusta, Ga. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna Belle McCallum
(b) Address 708 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location

18 (a) Funeral director Mrs Ratie R. Williams
(b) Address 322 N. Schroeder Str

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 23, 1948, at 8: p. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of lungs and heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-23-48 at Approx. 8 P. M.
(b) Where did injury occur? Josephine & Pine Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature [signature] M.D. Medical Examiner.

Date signed 10-24-48

X

G68016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Shell Bank Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Shell Bank Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Jefferson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas Jefferson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16, 1893.

8. AGE: Years 54 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Belton, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Smith.
13. Birthplace S.C.

MOTHER
14. Maiden Name Ola Greer
15. Birthplace S.C.

16 (a) Informant John Jefferson.
(b) Address 1212 Shellbank Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 26 1948 (Date received by registrar) (b) Huntingtown, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1948 to Oct 23 1948. and that I last saw her alive on Oct 23 1948.

Immediate cause of death Endocarditis

Duration (unknown)

Due to Cardiac Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place)
(e) Means of injury
23. Signature C. M. Lawrence M. D.
Address 1033 W Lanvale St Date signed 10-20-48

VS 150

G68017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Garrison Boulevard
(c) Hospital or institution: 15 DS
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
69	4		hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Retired
11. Industry or Business

FATHER
12. Name Samson
13. Birthplace Lith

MOTHER
14. Maiden Name Kuchner
15. Birthplace Lith

16 (a) Informant Sarah Davis
(b) Address 3011 Garrison Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Woodson Mde Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1100 Eastern Place

19 OCT 26 1948 Washington Nathaniel M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Oct. 1948, and that I last saw him alive on Oct 23, 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. T. Resnekov M.D.
Address 7210 Liberty Highway Date signed 10/26/48

VS 150

668018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 668018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 706 Nortonia Road

(c) Hospital or institution: The Mount 15 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2629 Loyola Northway (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ida Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business

FATHER

12. Name Hessel

13. Birthplace Russia

MOTHER

14. Maiden Name Rose

15. Birthplace Russia

16 (a) Informant Louis Goldberg

(b) Address 2629 Loyola Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)

(c) Cemetery or crematory Loudale

Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 760 Eutaw Place

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1948 at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1948 to Oct 21 1948, and that I last saw h[illegible] alive on Oct 21 1948.

Immediate cause of death Cancer of the cervix of the uterus — Duration 3½ yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George Shapiro M.D. M. D.

Address 5106 Park Heights Ave Date signed 10/26/48

VS 150

668019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 ✓ Registered No. 668019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Pall Mall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Soyphler (Zoypher)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation House Work
11. Industry or business

FATHER 12. Name Morris Joseph
13. Birthplace Russia
MOTHER 14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Hamilton Ave & Pratt Rd

18 (a) Funeral director Jack Levi Inc
(b) Address 1100 Eutaw Pl Baltimore, Md

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) 6 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1948, to 10-25 1948, and that I last saw her alive on 10-25 1948.

Immediate cause of death myocardial infarction
Due to coronary insufficiency
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roger Strauss M. D.
Address Sinai Hosp Date signed 10-25-48

VS 150

668020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A Cavalier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Esther Cavalier
(b) Address 3800 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Druid Hill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct 1948 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Oct 1948 to 25 Oct 1948 and that I last saw him alive on 25 Oct 1948.

Immediate cause of death Coronary Thrombosis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto Gen. Hosp. Date signed 25 Oct 48

VS 150

(68) Gerard 1320 N Charles 21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓ Registered No. 668021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Berry St
(c) Hospital or institution: 13 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Berry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L Seitz ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Levi B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14-1871

8. AGE: Years 77 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Sloontz
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16. (a) Informant Mrs Marie A Still
(b) Address 724 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 26 St

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct. 25 1948.
and that I last saw h[illegible] alive on Oct. 24 1948

Immediate cause of death	Duration
Bronchopneumonia	10 days
Due to Carcinoma of Breast	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Gerard
Address 1500 N. Charles St Date signed Oct 26 1948

VS 150

EC-LP-23057

668022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered No. 668022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 6,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Seidel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Santmyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-48

8. AGE: Years | Months | Days | If less than one day hr. 70 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert Gill Santmyer
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Emily Margarette Erskine
15. Birthplace Baltimore Maryland

16 (a) Informant Mr. Robert Santmyer
(b) Address 4230 Seidel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date filed by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 10-25 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1948 to 10-25-1948, and that I last saw her alive on 10-25-1948.

Immediate cause of death: cardiac failure — Duration

Due to premature separation of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Bon Secours Hosp Date signed 10/27/48 M D

VS 150

G68023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town [BALTIMORE] Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Melvin Ave. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Rose

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna E. Rose
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 9/19/1878

8. AGE: Years 70 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Deceased (John Rose)
13. Birthplace Scotland

MOTHER
14. Maiden Name Deceased (Susan Talbot)
15. Birthplace Nova Scotia

16 (a) Informant Mrs. Edna E. Rose
(b) Address 118 Melvin Ave, Catonsville

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19[illegible] at 6:40 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/25 1948 to 10/25 1948 and that I last saw him alive on 10/25 1948

Immediate cause of death Coronary Occlusion — Duration
Due to Generalized Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lenicka
Address St. Agnes Hosp. Date signed 10/25/48 M.D.

Herbert J. Lenicka

G68024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

G68024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-04

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME: JAMES JAMESON SKINNER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 087-12-8371

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Anna G. Skinner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	11	hr. min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Chief Engineer
11. Industry or business: Maritime Commission

FATHER
12. Name: Charles Skinner
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Mary Forsyth
15. Birthplace: Scotland

16 (a) Informant: Mrs. Anna G. Skinner
(b) Address: 1203 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month, day, year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 26 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19 , at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Strangulation

Due to

Other Conditions: Marked depression
(Include pregnancy within three months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/25/48 at 4:00 P.M.
(b) Where did injury occur? 1203 Bolton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home (Specify) No
(d) Means of injury: Self Inflicted

23. Signature John R. Divers, M.D.
Medical Examiner.
Date signed 10/26/48

G68025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 C

Registered No. G68025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3114 N. Calvert St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3114 N. Calvert St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY LOVELACE ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-4320

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 10, 1867

8. AGE: Years	Months	Days	If less than one day
81	6	15	hr. min.

9. Birthplace Spauling, Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Rev. Thomas A. Allen

13. Birthplace Georgia

MOTHER

14. Maiden Name Emma W. Tarver

15. Birthplace Georgia

16 (a) Informant Mr. Howard L. Clark

(b) Address 207 Elm St., Elmira, N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltp., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948, to Oct. 25 1948, and that I last saw h[illegible] alive on Oct. 27 1948.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to Arteriosclerosis, generalized Hypertension Cerebrovascular disease	
Due to [illegible]	
Other Conditions Hypertrophic prostate with Retention (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. D.

Address Date signed

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668026 4 of 7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 8316 ✓ Registered No. 668026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MD. ROPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Princeton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oakey Meadows
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Carrie Meadows
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) 5-12-92

8. AGE: Years	Months	Days	If less than one day
56	5	13	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Deputy Sheriff
11. Industry or business

FATHER 12. Name Ben Meadows
FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden Name Virginia Cole
MOTHER 15. Birthplace W. Va.

16 (a) Informant MD. ROPKINS HOSPITAL
(b) Address BROADWAY & MONUMENT ST.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory PRINCE
Location PRINCE W. VIRGINIA

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St Paul St.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948

Immediate cause of death: Cerebral Thrombosis — Duration
Due to: Atherosclerosis
Due to:
Other Conditions
(Include pregnancy within three months of death)

Date of operation 24 Oct 48
Major findings of operation: Cerebral edema
of autopsy: Cerebral thrombosis

PHYSICIAN
Underline the cause to which death should be assigned statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 10/26

668027 Herman

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 548

Registered No. 668027

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6707 Youngstown Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6707 Youngstown Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR J. MISKIMON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Dragler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/ 27/ 10

8. AGE: Years	Months	Days	If less than one day
38	7	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Arthur E. Miskimon
13. Birthplace Balto.

MOTHER
14. Maiden Name Ida May Thomas
15. Birthplace Balto.

16 (a) Informant Elizabeth Miskimon, (wife)
(b) Address 6706 Youngstown Ave.

17 (a) Burial (b) Date thereof 10/ 27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.
18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street
Oct 26 1948
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/48 19 . at 11 05 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 19 48 to 10/23/48.
and that I last saw h alive on Oct 22/48.

Immediate cause of death Metastasis — Duration 2 mos.
Right Frontal Lobe
Due to
Due to
Other Conditions Suppuration — 6 days
Mouth Gum
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Neoplasm
Gross Examination
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. J. Herrman, M.D.
Address 1710 E 33 St Date signed 10/25/48

VS 150

X 18

G68028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G68028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hosp.
(c) Hospital or institution: Lombard Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Hampden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ayres.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Flora Ayres

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 2 1890

8. AGE: Years 58 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Oilman

11. Industry or business

FATHER
12. Name William Ayres
13. Birthplace Md.

MOTHER
14. Maiden Name Georgia Hersch
15. Birthplace md

16 (a) Informant Edgar Ayres.
(b) Address 4512 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/48 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Park Hall, Maryland

18 (a) Funeral director Morris V. Williams
(b) Address Charlestown Maryland

OCT 26 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948 at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 25 1948.
and that I last saw h[illegible] alive on Oct 25 1948.

Immediate cause of death
cardiac failure
Due to arteriosclerotic Coronary
Due to artery disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Dean M. D.
Address Univ Hosp Date signed Oct 25 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

-BC. 48-2264 BALTIMORE CITY HEALTH DEPARTMENT ✓ G68029 Registered No.
G68029 CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY PORTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1948

8. AGE: Years | Months | Days | If less than one day: hr. 38 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Agnes Porter
15. Birthplace 1110 W. Lafayette Ave.

16 (a) Informant Agnes Porter
(b) Address 1110". Lafayette Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
UNIVERSITY MEDICAL SECTION AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 OCT 26 1948 (Registered by Registrar) (b) Huntington Williams M.D.

VS 15+

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948, at 7.38 P M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity, atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed August 9, 1948

X

G68030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G68030 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Calvin Ave. #18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HENRY DAVIS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nina Whaland
6 (c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.) 4/24/81
8. AGE: Years 67 Months 6 Days 2 If less than one day ____ hr. ____ min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles E. Davis
13. Birthplace Rock Hall, Md.

MOTHER
14. Maiden Name Angeline Cabrera
15. Birthplace Hayes Cove, Maryland

16 (a) Informant Mrs. Louisa Pack (daughter)
(b) Address 416 Calvin Ave. #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Chapel
Location Rock Hall Md

18 (a) Funeral director Eckert & Lane
(b) Address Chestertown Md

19 OCT 27 1948 (Date rec'd by registrar) (Registrar's signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948 at 5 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1948 to 10/26 1948.
and that I last saw h alive on 10/26 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	1 hr.
Due to Hemorrhage	2 days
Due to Bleeding Peptic Ulcer	16 years (Or between)
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Sapstead M.D.
Address Md. Sel. Hosp. Date signed 10/27/48

VS 190

G68031 n3 ✓ 13 c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68031

LCH-83076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1798 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Dietrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Arthur C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/1 (~~1877~~) 1870

8. AGE: Years (75) 78 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacobs
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 OCT 27 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19 , at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6/43 19 , to 10/25/48 19 , and that I last saw h er alive on 10/25/48 19 .

Immediate cause of death Bronchopneumonia RLL LLL — Duration 3 weeks

Due to

Due to Hypertensive arteriosclerotic

Other Conditions Heart disease
Hypertrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Maurer
Address Balto City Hosp Date signed 10-25-48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G680 ~~To Be~~ APPROVED

BALTIMORE CITY HEALTH DEPARTMENT

Medical Examiner Case CERTIFICATE OF DEATH 186a

Registered No. G68032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home and Hospital 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. 23rd St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Young

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 24, 1878

8. AGE: Years 70 | Months 5 | Days / | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Anton Young
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Hillinginist
15. Birthplace Germany

16 (a) Informant Cleone Hooker
(b) Address Church Home Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1017 St. Paul St.

19 OCT 27 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948, at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948, to Oct 25 1948 and that I last saw h[illegible] alive on Oct 25 1948.

Immediate cause of death: Epidural - Hemorrhage and Laceration into left cerebral Hemisphere — Duration 12 hrs

Due to: Fracture of skull in left temporal area — 12 hrs

Other Conditions: Fractures of both radii and of left little finger

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: CERTIFICATION APPROVED BY [illegible] for John R. Oruvio M.D. Medical Examiner

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9-08
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct 25, 1948 at 6 A M
(c) Where did injury occur? 722 E. 23rd St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Accidental fall down stairs

23. Signature Vernon F. Norwood M. D.
Address Church Home & Hospital Date signed 10-26-48

VS 153

G680333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G680333
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Howard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA MIX

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1856

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	2	9		

9. Birthplace W Va (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER	12. Name Henry Schultz
	13. Birthplace Germany
MOTHER	14. Maiden Name Anna K. Roper
	15. Birthplace England

16 (a) Informant Mrs Catherine Bayless
(b) Address 1510 Porter St Phila

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore Md

18 (a) Funeral director Wallace Cook Inc
(b) Address 1217 St Paul St

19 (a) OCT 27 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1948, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948, to 10-25 1948, and that I last saw h alive on 10-25 1948

Duration

Immediate cause of death Cerebral Embolism

Due to Auricular fibrillation

Due to Hypertensive Arteriosclerotic C V Disease

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Nicholas M D
Address University Hospital Date signed 10-25-48

VS 150

G68034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49a

Registered No. G68034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 West West St
(c) Hospital or institution: 7-1-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. West St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Luckett Pape

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Cliver Pape
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Nov. 2, 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
54	11	13		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Luckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Druselle Farner
15. Birthplace Maryland

16 (a) Informant Cliver Pape
(b) Address 541 W. West Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27th (month) (day) (year)
(c) Cemetery or crematory Boyd Md
Location Boyd Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley e

19 (a) Date received by (Registrar) Oct 27 1948 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948. 5:30 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1948 to Oct 25 1948.
and that I last saw her alive on Oct. 16 1948

Immediate cause of death Respiratory failure — Duration
Due to Carcinoma Ovary.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Aborafas M.D.
Address 601 N. Monroe St Date signed 10/29/48 M.D.

X

68035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 ✓ Registered No. 668035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 21 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Aisquith Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian C. Salzmann Salzmann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 30 | Months 3 mo | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER 12. Name John J. Eigner
13. Birthplace Balto. City Md.

MOTHER 14. Maiden Name Katherine A. Killian
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. J. J. Eigner
(b) Address 3521 Aisquith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Hanahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Oct 27 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948 at 11 20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/21 1948 to 10/26 1948
and that I last saw her alive on 10/26 1948

Immediate cause of death: Respiratory failure — Duration

Due to

Due to Tonsilosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cancer of tonsil with extension to pharynx and glands of neck

Findings of autopsy: Autopsy Not Performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Blazek, M.D.
Address Date signed 10/26/48

VS 150

Blazek

668036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. 668036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Bank St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1818 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Beckmann

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 5th 1870

8. AGE: Years	Months	Days	If less than one day
78	5	20	hr min.

9. Birthplace New Orleans La. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Rosa George
15. Birthplace New Orleans La

16 (a) Informant Joseph Beckmann
(b) Address 1818 Bank St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30th 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Crook
(b) Address 1701-03 N. Patterson Park ave

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address Date signed 10-16-48

VS 150

668037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1923

8. AGE: Years	Months	Days	If less than one day
24 25	11	25	hr. min.

9. Birthplace Raleigh, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Henry Knott

FATHER
12. Name George Adams
13. Birthplace Raleigh, N. C.

MOTHER
14. Maiden Name Lizzie Horton
15. Birthplace Raleigh, N.C.

16 (a) Informant Percy Horton
(b) Address 1909 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Raleigh, Location north Carolina

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 OCT 27 1948 (Date rec'd by local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at 10.00 a.m.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What was he doing?)
(d) Means of injury

23. Signature Earl L. Royster M.D. (Medical Examiner)
Date signed October 25, 1948

VS 1ST

G68038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G68038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W. SARATOGA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HOLLAND.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ??? ?

8. AGE: Years 41 ? | Months | Days | If less than one day ... hr. ... min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM (D)
13. Birthplace MD.

MOTHER
14. Maiden Name JOSEPHINE SCOTT.
15. Birthplace MD.

16 (a) Informant B.C.H. RECORDS.
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus memorial Pk
Location Arbutus Md

18 (a) Funeral director Robert E. Fitzsimmons
(b) Address 15 15 McElderry St

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-48 19 at 820 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22-48 19 to 10-23 19 43 and that I last saw HIM alive on 10-23-48 19

Immediate cause of death Pulmonary edema — Duration 1 day

Due to Hypertensive Arteriosclerotic Rheumatic Heart Disease — Duration 3-4 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. S Stutzman, M.D.
Address Balto. City. Hosp. Date signed 10-25-48

VS 130

X

CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. Every item of information should be carefully supplied. TYPE OR PRINT IN INK, WITH UNFADING INK.

G68039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6504 Brighton Ave.,
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6504 Brighton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Manning,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female | **5. Color or race** white | **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife James P. Manning.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1884

8. AGE: Years 64 | Months 7 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Ireland.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name Daniel Carroll,
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Boyle,
15. Birthplace Ireland.

16 (a) Informant Mr. James P. Manning.
(b) Address 6504 Brighton Ave.,

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 10/28/48 (month) (day) (year)
(c) Cemetery or crematory St. Charles Cem.
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 OCT 27 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948 at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to 10/25 1948, and that I last saw her alive on 10/25 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Hypertensive Cardiovascular disease	+ yrs
Due to: Pernicious anemia	+ yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 4843 Park Heights. **Date signed** 10-26-48

G68040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES R. SCOTT

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 380-05-6085

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laura J. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Maroh 31, 1899

8. AGE: Years 49 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace: Bradford, Mass.
(Town, county, and state)
10. Usual Occupation: Resident Comptroller
11. Industry or business: Fisher Body Div. of Balto.

FATHER
12. Name: Charles Scott
13. Birthplace: Canada

MOTHER
14. Maiden Name: Bernice Nash
15 Birthplace: Brasher Falls, N. Y.

16 (a) Informant: Mrs. Laura J. Scott
(b) Address: 2930 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory
Location: Amesbury, Mass.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 OCT 27 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1948 at 10.15P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Oct 25 1948, and that I last saw h[illegible] alive on Oct. 25 1948.

Immediate cause of death: Coronary Thrombosis — Duration: Immediate
Due to
Due to
Other Conditions: Duodenal ulcer — Duration: many years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M.D.
Address 100 E. 23rd St Date signed Oct 25-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

G68041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Loudon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CONDON ELLSWORTH VARINA

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Martha E. Varina

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1861

8. AGE: Years 87 | Months 8 | Days 1 | If less than one day: hr min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Hardware Dealer (retired)

11. Industry or business:

FATHER
12. Name: Edward Varina
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Mary Disney
15. Birthplace: Maryland

16 (a) Informant: Mr. James Varina
(b) Address: 2804 Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Funeral Director, Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Oct. 25 1948, and that I last saw h[illegible] alive on Oct. 23 1948.

Immediate cause of death: Coronary Occlusion — Duration:

Due to: Senility

Due to:

Other Conditions: Chr. Nephritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George E. Shannon M.D. M. D.
Address: 820 Medical Arts Bldg Date signed: 10/26/48

744

668042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84a

Registered No. 668042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Charles

(c) City or town Port Tobacco (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Compton (Margaret) (235231)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1, 1948

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Colvin Compton

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Selby

15. Birthplace Maryland

16 (a) Informant Hospital Record

(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) OCT 27 1948 (b) [illegible] for Williamson

(Date rec'd by registrar)

VS 150

VOID

SEE 6723

6

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1948 to October 17 1948, and that I last saw her alive on October 17 1948.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Mongolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul D Burns M. D.

Address Johns Hopkins Date signed 10/28/48

161a

668043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 668043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 N Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Henry Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colard | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/6/81

8. AGE: Years 67 | Months 8 | Days 19 | If less than one day: hr min.

9. Birthplace East New Market Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William Thompson
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Thompson
15. Birthplace Maryland

16 (a) Informant Myrtle E Smyrey
(b) Address 603 N Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Thompson Town church
Location East New Market Md

18 (a) Funeral director Wm A Jackson
(b) Address 966 Penna Ave

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1948 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 10/25 1948.
and that I last saw her alive on 10/25 1948

Immediate cause of death (a) Arteriosclerotic Heart Disease | Duration ?

Due to (b)

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William E Danner M.D.
Address 253 George St Date signed 10/28/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

68044 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 S. Patterson Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 S. Patterson Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Branislawa Rutkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Julian Rutkowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name Maciej Palanowski
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina Koscielska
15. Birthplace Poland

16 (a) Informant Mrs. Julian Rutkowski
(b) Address 224 S. Patterson Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John F. Weber
(b) Address 401 S. Chester St

19 (a) 29 1948 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION 9 10

20. DATE OF DEATH Oct 25 1948 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1948 to Oct. 26 1948. and that I last saw her alive on Oct. 4, 1948.

Immediate cause of death	Duration
Arteria sclerotic cardio-vascular disease	years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M. D.
Address 408 S. Patt. Pk. Ave Date signed 10/26/48

VS 8

X

G68045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 306 N Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Needham (Needom)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Charles Needham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67				

9. Birthplace Warrington Co (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Arundle Co Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna

19 (a) (b)
20 (Signature of person) by registrar Lexington Williams, M.D. registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/48 19 . at 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/48 to 10/23/48 and that I last saw h alive on 10/23/48

Immediate cause of death: Uremic Myocarditis — Duration: years
Due to Chron Sclerosis
Due to Senility
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter T Loxton
Address 502 Edmondson Date signed 10 28 48

MUST BE WRITTEN PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68046 Registered No. 131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 PENNA AVE
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 PENNSYLVANIA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD EARLY

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-5447

4. Sex MALE | 5. Color or race COL | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ELIZABETH

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 4-7-1914

8. AGE: Years 30 | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace WILSON N. C. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business —

MOTHER | FATHER
12. Name EDGAR L. EARLY
13. Birthplace N. C.
14. Maiden Name HATTIE VALENTINE
15. Birthplace N. C.

16 (a) Informant ELIZABETH EARLY
(b) Address 926 PENNA. AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Conway MD
Location Pottsburg MD

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

(Date rec'd by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT-29 1948 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to Oct 29 1948 and that I last saw him alive on Oct. 20 1948

Immediate cause of death: Pulmonary collapse — Duration: 17 MOS

Due to: Pulmonary Tuberculosis

Due to:

Other Conditions: Cirrhosis. Edmundson (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. M. S. K. Reedy M. D.
Address 756 Dolphin St Date signed 11/27/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G68047

ES- 122823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a Registered No. G68047

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Jones

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58?			hr. min

9. Birthplace Unable to Obtain Information.
(Town, county, state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) _____ (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 2 8 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1948 at 1:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-9-48 to 9-23 1948 and that I last saw her alive on 9-23 1948

Immediate cause of death Uremia — Duration 10 days

Due to Chronic pyelonephritis or arteriolar nephrosclerosis — Duration 19 years

Due to

Other Conditions Hypertensive heart disease Old hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature David H. Marvin M.D.
Address Balto City Hosp Date signed 10-28-48

VS :50

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68048

AB–109128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30e

Registered No. G68048

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1519 Riggs Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No) Yes

If yes, name country

3 (a) FULL NAME Howard Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15- 1892

8. AGE: Years	Months	Days	If less than one day
56	4	8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name George Williams

13. Birthplace Md.

MOTHER

14. Maiden Name Lisa ?

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 26 1948

18 (a) Funeral director

(b) Address

19 (a) OCT 28 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 4 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-13---- 1947, to 10-7- 1948, and that I last saw him alive on 10-7- 1948

Immediate cause of death Cardiac failure — Duration

Due to Syphilitic heart disease aortic insufficiency

Due to

Other Conditions General paresis Old amputation left leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)

(e) Means of injury

23. Signature David Marine

Address Balto City Hosp. Date signed 10-11-48

VS 150

G68049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13L Registered No. G68049

LCH-123060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos. or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Lexington Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME LEE RICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/15/1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen F. Ricks
13. Birthplace N.C.

MOTHER
14. Maiden Name Maria ?
15. Birthplace N.C.

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address OCT 26 1948

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/48 (Month) (Day) at 4:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/17/48 to 10/17/48 and that I last saw him alive on 10/17/48

Immediate cause of death Bilateral Pulmonary advanced tuberculosis — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Frank W. Shipley M.D.
Address Balto. City Hosp. Date signed 10/21/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

68050
JL - 124015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137 Registered No. G68050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Green St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Emma Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	21	hr min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 astern Ave.

17 (a) Burial (b) Date thereof Oct 29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1058 W Monument St

19 (a) (b) Huntington Williams, M.A.
(Date received by local registrar) Registrar

OCT 27 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948 at 11.40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 24, 1948 to Oct. 25 1948 and that I last saw h im alive on Oct. 25 1948.

Immediate cause of death
Uremia — Duration 1 wk
Due to Bilateral pyonephrosis and hydronephrosis — Duration 2 yr. over
Due to Benign Prostatic hypertrophy — Duration 3-4 yr.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-26-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668051

Leh 16062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

668051
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick St. & Fayette St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

Balto City Hosp

3 (a) FULL NAME George Oeste

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	19	hr min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER	12. Name John Oeste
	13. Birthplace ? Germany
MOTHER	14. Maiden Name Era Stock
	15. Birthplace ? Germany

16 (a) Informant Balto. City Hospl records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/48 19 at 19:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/14 19 to 10/1/48 19 and that I last saw him alive on 10/1/48 19

Immediate cause of death Bronchopneumonia — Duration 20 days

Due to

Due to

Other Conditions Surgical absence of rt eye. Basal cell carcinoma of skin of eyelid (?)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Marine M.D.
Address Balto City Hospls Date signed 10-4-48

VS 150

107

Cc 48-23505
G68052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a G68052 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Guilford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Martin ~~Ayers~~ Ayers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-25-48

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day hr. min. 3

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER 12. Name Ira L. Ayers

13. Birthplace Tenn.

MOTHER 14. Maiden Name Dessie Hillen

15 Birthplace Tenn

16 (a) Informant Father (Ira L. Ayers)
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Baltimore Co. Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 802 N. Calvert St.

OCT 27 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1948 at 9:55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1948 to 10-27-1948.
and that I last saw h~~e~~r alive on 10-27-1948.

Immediate cause of death	Duration
Resp. failure	
Due to Intracranial Hemorrhage	5-7 hrs
Due to Erythroblastosis fetalis	3 days (Life)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 10-27-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68053

BALTIMORE CITY HEALTH DEPARTMENT 13 1a ✓

CERTIFICATE OF DEATH X

Registered No. G68053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore (Same as dec'd)
(c) City or town North Linthicum, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Charles Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Laura Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) 12/3/1881

8. AGE: Years	Months	Days	If less than one day
66	10	23	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Fisher
13. Birthplace Switzerland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Mr. Wm J. Becker
(b) Address 5 Charles Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director L. J. Tabbey & Sons
(b) Address 1818 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

VR Form 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948 at 3:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/26 1948, and that I last saw her alive on 10/26 1948.

Immediate cause of death	Duration
Acute congestive myocardial failure	6 hours
Due to Acute coronary thrombosis	12 hours
Due to Hypertensive-Arteriosclerotic Cardiovascular-Renal Disease	? years
Other Conditions Pulmonary edema	6 hours

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 10/26/48 Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Blum M. D.
Address Maryland General Hosp. Date signed 10/26/48

X

668054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668054
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Esther Grolman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Late Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 14, 1867

8. AGE: Years 80 | Months 11 | Days 13 | If less than one day hr. min

9. Birthplace Lativa
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Arron Deitch
13. Birthplace Lativa

MOTHER
14. Maiden Name Laura ?
15. Birthplace Lativa

16 (a) Informant Arther Raffel
(b) Address 2903 Mt Holly St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Oct, 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948, to Oct. 27, 1948. and that I last saw her alive on Oct. 27, 1948.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Coronary Thrombosis

Due to Arterio Sclerotic Heart Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place?
While at work?
(d) Means of injury

23. Signature Ray C. Parsons Jr. M.D.
Address 1. Joseph's Hosp. Date signed 10/27/48
M D

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

68055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1957

Registered No. 68055

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1003 Sterrett St

(c) Hospital or institution: 7-1-01

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 Sterrett St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Augusta Zelinka

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1914

8. AGE: Years	Months	Days	If less than one day
34	8	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Technician

11. Industry or business Mercy Hosp.

FATHER

12. Name Joseph Zelinka

13. Birthplace Austria

MOTHER

14. Maiden Name Margaret Pisna

15 Birthplace Md.

16 (a) Informant Paul A Zelinka

(b) Address 2205 Reedy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Balto. Md

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St Paul St

19 OCT 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948, at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948 to 10-26 1948, and that I last saw h[illegible] alive on 10-26 1948.

Immediate cause of death

Congenital Heart Disease

c Ventricular Septal Defect

Due to c Complete Heart Block

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation: None done

of autopsy:

Duration

birth

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Alan Gilman, M D

Address 1401 E. Lafayette Ave Date signed 10-27-48

Johns Hopkins Hosp

VS 150

G68056

J1 - 89252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G68056 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. No Home Address (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME William Flint

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No Record

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1901

8. AGE: Years 46 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Flint
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Gray
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948, at 6.30 Am M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1944 to Oct. 26 1948.
and that I last saw him alive on Oct. 26 1948.

Immediate cause of death Bronchopneumonia — Duration
R.L.L.
Due to LAENNEC'S CIRRHOSIS
Due to Myeloxyphoitis
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
ABOVE
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren E. Porter M.D.
Address Balto. City Hospitals Date signed 10/26/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. 668057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 N. ELLWOOD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No).
If yes, name country

3 (a) FULL NAME CLEMENTINA FIORELLI

3 (b) If veteran, name war	3 (c) Social Security Account No. NONE
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife VERINO FIORELLI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 1 1894

8. AGE: Years	Months	Days	If less than one day
53	10	26	hr. min.

9. Birthplace ITALY
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name DOMINCK CAPANNA
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant EDITH WEINBERGER
(b) Address 1332 N. ELLWOOD AVE

17 (a) Burial (b) Date thereof 10/30/48
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 327 St. Paul St.

19 OCT 28 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1946 to 7-19 1948 and that I last saw h ~~er~~ alive on 7-19-1948.

Immediate cause of death arterio Sclerotic heart disease 2
hypertension
Due to Cerebral arterio Sclerosis 2
Cardiac enlargement
Due to arterio Sclerosis

Other Conditions Chronic gall-bladder disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. A. Michelson M. D.
Address 2230 Eutaw Pl. Date signed 10/29/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6680:58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6680:58

The information requested on this certificate is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 15, Box 166 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nesitt Edwards

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife Bertha Edwards 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 8-16-89

8. AGE: Years	Months	Days	If less than one day
59	2	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Shipyard Carpenter
11. Industry or business

FATHER
12. Name Philip Edwards
13. Birthplace England

MOTHER
14. Maiden Name T. Betterton
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Orems Methodist
Location Middle River, Md.

18 (a) Funeral director Kavanaugh Funeral Service
(b) Address 7 E. Belair Road

19 (d) OCT 28 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948, to 10-26 1948, and that I last saw him alive on 10-26 1948.

Immediate cause of death	Duration
Cerebral vascular Thrombosis in region of hypothalamus	
Due to Cerebral arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Thrombosis of basilar artery with cerebral softening

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. W. Jackson M. D.
Address The Johns Hopkins Hosp. Date signed 10/27/48

VS 150

68059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 68059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5823 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5823 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS E. O'HARE, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-1238 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Henrietta E. O'Hare

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13th, 1879

8. AGE: Years	Months	Days	If less than one day
68	11	13	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Mill Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Hugh O'Hare
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Fitzimmons
15. Birthplace Ireland

16 (a) Informant Mrs. Louis E. O'Hare, Sr.
(b) Address 5823 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Oct 28 1948 (b) Registrar Huntington Williamson Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26th, 19 48, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 26 1948, and that I last saw him alive on Oct 25 1948

Immediate cause of death
Cerebral Hemorrhage — Duration 2 wks.
Due to Arteriosclerosis — many yrs.
Due to
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark K. English M. D.
Address 5713 Belair Rd Date signed 10-27-48

Mark K. English

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668060 123991

B.C. 48-28873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 a 668060 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. city hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence T. Larkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 48

8. AGE: Years	Months	Days	If less than one day
5 wks.	1	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Ruth Larkins.
15. Birthplace Md.

16 (a) Informant Records, Balto. city Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 OCT 28 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-48 19 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/ 19 48 to 10/23/ 19 48 and that I last saw her alive on 10/23/ 19 48

Immediate cause of death	Duration
Meningitis Staphylococcal	2 hrs.
Due to Staphylococcal Sepsis	2 wks.
Due to	
Other Conditions: Prematurity.	5 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed

M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully prepared.

X

668061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66801

B 71123527 48-2094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Back River Neck Rd. -21 (If rural give location)
(e) Citizen of foreign country? Yes or No) Yes
If yes, name country

3 (a) FULL NAME: David M. Aldao

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept. 26. 1948.

8. AGE: Years	Months	Days	If less than one day hr.	min.
—	—	29		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rex Aldao
13. Birthplace Italy

MOTHER
14. Maiden Name Florina Bowen
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-26-48 9 am (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 5.45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1948 to Oct. 25 1948. and that I last saw h[illegible] alive on Oct. 25 1948

Immediate cause of death	Duration
Intussusception	3 wks.
Due to Diarrhea of unknown	3 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Intussusception

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10-26

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be certain all items are supplied. Use

G68062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

Registered No. G68062

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 Belt Street
(c) Hospital or institution:
1704
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Belt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS YANKE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Wilhelminia Kintop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1875

8. AGE: Years	Months	Days	If less than one day
73	2	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name William Yanke
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta ?
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway, Brooklyn
18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue
19 (a) OCT 28 19[illegible] (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 12:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1948 to Oct 25 1948
and that I last saw h[illegible] alive on Oct 24 1948.

Immediate cause of death — Duration

Carcinoma Rectum.

Due to —

Due to —

Other Conditions Hypertension. Broncho-pneumonia (Terminal)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius C. Schenuit M. D.
Address 133 S. Charles St Date signed 10/28/48

VS 190

G68063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131

Registered No. G68063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 Tenpin Alley
(c) Hospital or institution: 5. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Tenpin Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence V. Lee

3 (b) If veteran, name war: 1
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Sep
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 11 1897

8. AGE: Years 50 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Caulker
11. Industry or business

FATHER
12. Name George Lee
13. Birthplace Md

MOTHER
14. Maiden Name Anabelle Brown
15. Birthplace Md

16 (a) Informant Wife Sadie Rawlins
(b) Address 1401 Tenpin Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 48 (month) (day) (year)
(c) Cemetery or crematory Mt. S. Balto National
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 28 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26th 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1948 to Oct 1948 and that I last saw him alive on 24th Oct 48

Immediate cause of death Advanced Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Frus M. D.
Address 118 Bigelow Date signed

VS 150

Please write age as especially important. Physicians: please write the causes of death clearly and legibly.

G68064
AB-123837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 136

G68064
Registered No.

Physicians: please write the causes of death clearly and legibly. Correct age is especially important. Items must be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Clanton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-12-1917

8. AGE: Years	Months	Days	If less than one day
31	7	13	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Rev. Samuel Clanton ¹D
13. Birthplace N.C.

MOTHER
14. Maiden Name Ella Thorne
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Norlina
Location N.C.

18 (a) Funeral director Rayner & Sanders
(b) Address 14 E. Preston St.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25- 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1948 to 10-25- 1948. and that I last saw him alive on 10-25- 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis	Several years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pulm tbc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Gayle Burton M D
Address Baltimore City Hospitals Date signed 10/26/48

VS 150

68065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered 68065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-05
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 24hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Latrobe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUNER MOSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1888

8. AGE: Years 60 | Months 7 | Days 4 | If less than one day hr. min

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Calvin Mays
13. Birthplace S. C.

MOTHER
14. Maiden Name Estella Montgue
15. Birthplace S. C.

16 (a) Informant Julia Cobert
(b) Address 123 W. 22cnd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 30-48 (month) (day) (year)
(c) Cemetery or crematory U.S. Balto National
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1415 E. Preston St

19 (a) OCT 28 1948 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948 19 , at 9:08 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Shock due to multiple contusions and fractures of the facial bones.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 26/48 at 3:30 A.M.
(b) Where did injury occur? Baltimore-Balt. Md.
Did injury occur at home, on farm, industrial place, in public place? Home While at work? Asleep
(d) Means of injury Blunt force

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 10/27/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 68066

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 N LOUDON AVE
(c) Hospital or institution:
2007
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. LOUDON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm A. Campbell, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of ~~husband~~ or wife late NELLIE V

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 23, 1894

8. AGE: Years	Months	Days	If less than one day
54	6	4	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation MANAGER

11. Industry or business NASH KELVINATOR

FATHER
12. Name MAC DOUGAL CAMPBELL
13. Birthplace SCOTLAND

MOTHER
14. Maiden Name ?
15. Birthplace U.S.A.

16 (a) Informant MALCOLM CAMPBELL JR
(b) Address 520 N. LOUDON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 30 '48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director Harry H Wilhelm
(b) Address 4101 Edmondson Ave, Huntington Woods, Md

19 (a) OCT 28 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 27 1948, at 12 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr M.D. Medical Examiner.
Date signed 27 Oct-48

VS 151

+

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6680-17

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 6680-17

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 N. Monastery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Paul Medford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary C. Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/1893

8. AGE: Years	Months	Days	If less than one day
55	0	3	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER 12. Name Isaac L. Medford

13. Birthplace Md

MOTHER 14. Maiden Name Margaret Boesel

15. Birthplace Md

16 (a) Informant Mrs Mary Medford

(b) Address 69 N. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 '48 (month) (day) (year)

(c) Cemetery or crematory New Catholic

Location Old Frederick Rd

18 (a) Funeral director Harry A Wilbur

(b) Address 2400 Eastern Ave

19 (a) OCT 29 1948 (Date rec'd by registrar) Courtesy Dr. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/26 1948, and that I last saw him alive on 10/26 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Coronary sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carlos J. Blanck M. D.

Address Maryland Gen. Hosp. Date signed 10/26/48

VS 190

668068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2529 Christian St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife Late KATHERINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 18, 1885

8. AGE: Years 63 69 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Thomas

13. Birthplace Md

MOTHER 14. Maiden Name Annie

15. Birthplace Md.

16 (a) Informant MRS LUCY A McKAY

(b) Address 2413 JAMES ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 29 '48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wiltze

(b) Address 4101 Edmondson Ave

19 (a) OCT 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1948 to 10/26 1948 and that I last saw him alive on 10/26 1948.

Immediate cause of death Cardiac Failure

Duration: Admit 8-5-48 Died 10/26/48 80 days

Due to Primary Bronchiogenic Ca of Left Lung & Abcess

Due to Formation

Other Conditions

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER

Date of operation 10/19/48

Major findings of operation: Ca of left lung & extension to abcess formation

of autopsy: Ca of Bronchus Original

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Tansey M. D.
Address St Agnes Hosp Date signed 10/27/48

VS 153

To be approved by Medical Examiner

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68069 Dr. Gordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41a ✓

Registered No. 68069

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5112 Richard Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5112 Richard Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian Frederick Moebus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace Aberdeen, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Moebus
13. Birthplace Germany

MOTHER
14. Maiden Name Mary F. Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Margaret C. Moebus
(b) Address 5112 Richard Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date received by Local Registrar OCT 28 1948 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948 at 1-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 27 1948, and that I last saw h in alive on Oct 26 1948

Immediate cause of death Carcinomatosis

Duration 1 year

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None

23. Signature H. F. Gordy M.D.
Address 7 Va Harford Rd Date signed 10/28/48

+

G68070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G68070 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Edison Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mother Mary Generosa, O.S.F.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name McCafferty
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Sr. M. Constantine
(b) Address 2810 Edison Hgway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)
(c) Cemetery or crematory Our Lady of Angels
Location Glen Riddle, Pa.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1948 to Oct 26 1948 and that I last saw her alive on Oct 26 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Hypostatic pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Personeni, M.D. M.D.
Address 21 E. Lafayette Ave Date signed 10/26/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ Registered No. G68071

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution West. Baltimore General 16 06
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2858 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Florence Norlamus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Norlamus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1884

8. AGE: Years	Months	Days	If less than one day
63 63	11	16	hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Patrick McCartin
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Katherine DiPaula
(b) Address 2858 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

OCT 28 1948 Received by registrar (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/48 19 . at 8:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/48 19 . to 10/27 19 48.
and that I last saw h alive on 10/27 19 48.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Dana M. D.
Address 10-27-48 Date signed 10-27-48

Wm Bolts Son Dog
x

VS 150

668072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1/2 Registered No. 668072

TYPE or PRINT. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Sharp Street
(c) Hospital or institution: 23 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Sharp Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lorraine Bass

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/16/1928

8. AGE: Years	Months	Days	If less than one day
19	10	4	hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wiley Bass
13. Birthplace N.C.

MOTHER
14. Maiden Name Carrie Lyons
15. Birthplace Baltimore, City

16 (a) Informant Carrie Bass
(b) Address 1125 Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem
Location Balto Co.

18 (a) Funeral director Sarah I. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) OCT 28 1948 (b) Date rec'd by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948, to Oct. 25, 1948 and that I last saw her alive on Oct. 20, 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 824 W. Franklin St Date signed 10-26-48

VS 150

68073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 2

Registered No. 68073

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35 N. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Joseph T. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	✓	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Paget
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Rudolf
15. Birthplace Germany

16 (a) Informant Joseph T. White
(b) Address 35 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Mayer
(b) Address 3006 E. Balt. St.

19 (a) OCT 28 1948 (b) Signature of registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 48, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1 48 to Oct 26 48, and that I last saw h[illegible] alive on 6 26 48

Immediate cause of death: Carcinoma — Duration

Due to Stab Incisions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kent Gurley M. D.
Address 2906 E Balt Date signed 10 28 48

VS 150

68074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68074

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SUTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife George Suter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1877

8. AGE: Years	Months	Days	If less than one day
71	8	4	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dallas E. Breshmiller
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name M. Martha Tatham
15. Birthplace Balto., Md.

16 (a) Informant Mrs. M. C. Collector, daughter
(b) Address 1821 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948 at 5:30 A M

21. I certify that death occurred on the date above stated, and that I attended deceased from Aug 1 - 48 to Oct 26 48, and that I last saw h[illegible] alive on Oct 25 48

Immediate cause of death Chronic nephritis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry C. Houck, M.D.
Address 1911 Mt. Hunter Pl. Date signed Oct 28/48

668075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. 668075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3443 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARLO LEONE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	none	male	white	married

6 (b) Name of husband or wife Virginia Leone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1888

8. AGE: Years	Months	Days	If less than one day
60	4	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Self

FATHER
12. Name Lewis Leone
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Virginia Leone
(b) Address 3443 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1948 to Octobr 27 1948, and that I last saw h im alive on Oct obr 25 1948

Immediate cause of death Myocarditis — Duration Months

Due to Arterio-sclerosis generalized — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Herman M D
Address 702 E. Preston St. Date signed 10/29/48

VS 150

G68076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G68076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 W Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard Briscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1873

8. AGE: Years 75 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Isabelle Friesen
(b) Address: 1421 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: October 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N Schroeder St

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Funeral Director for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24, 1948, at 8.10 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 10/25/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68077

FL - 123954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68077
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Galloway

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Alberta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 29. 1871

8. AGE: Years	Months	Days	If less than one day
77	6	28	hr min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Galloway
13. Birthplace Md.

MOTHER
14. Maiden Name Melinda Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct. 30, 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Am.
Location

18 (a) Funeral director Mrs. Ketie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1948, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1948, to Oct. 27 1948, and that I last saw him alive on Oct. 27 1948.

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Cardiac failure	2-3 wk.
Due to Arteriosclerotic Heart Disease	3-4 yr.
Other Conditions Bronchopneumonia	1 wk.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Stutzmon M. D.
Address Balto. City Hosp. Date signed 10-27-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only black ink. Do not abbreviate. Answer every question.

G68078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C

G68078 Registered No.

1. PLACE OF DEATH: 2476 Shirley Ave
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Avenue Road
(c) Hospital or institution:
Mt Carmel Home 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Kaffeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Wife

FATHER
12. Name: Usher Presman
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Poland

16 (a) Informant: Gershon Kaffeman
(b) Address: 3730 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 29, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date received) (b) (Registrar)
OCT 29 1948 Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Oct 28 1948, and that I last saw her alive on Oct 27 1948.

Immediate cause of death: Cerebral Embolism — Duration: 1 wk.

Due to: Arteriosclerosis + Cardiac Hypertrophy +

Due to: Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Rachel H. Kalman M.D.

Address: 3700 Park Heights Ave. Date signed: Oct 28 1948

Medical Examiners Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Mc Elderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Harris

3 (b) If veteran, name war 0

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-17-1913

8. AGE: Years	Months	Days	If less than one day
35	3	8	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benny Harris
13. Birthplace ?

MOTHER
14. Maiden Name Mattie Coleman
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28-48 (month) (day) (year)
(c) Cemetery or crematory
Location Columbian, D. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Booty ave

19 OCT 28 1948 (Date received by Registrar) Huntington Hillsdale, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 5 EDP. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948

Immediate cause of death UNDETERMINED — Duration

CERTIFICATION APPROVED BY

Due to

Due to M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

Other Conditions SPONTANEOUS PNEUMOTHORAX - ? PULMONARY TUBERCULOSIS — UNKNOWN
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE PERFORMED

of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature C.L. Leyton
Address c/o Johns Hopkins Hosp. Date signed 10-25-48 M. D.

VS 193 Certificate to be Approved by Medical Examiner

Physicians: please write the causes of death clearly and legibly.

Dr. Harding
3805 Belair

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668080

668080

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5414 Gerland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5414 Gerland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Herbert White

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9933

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 20, 1898

8. AGE: Years	Months	Days	If less than one day
50	8	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Purchasing Agent
11. Industry or business Gen. Ship Rep. Co.

FATHER
12. Name Frederick White
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Gibbons
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Emma White
(b) Address 5414 Gerland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 28 1948 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th 1948, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from: March 1948 to Oct 27 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death (a) Myocarditis — Duration 8 mo
Due to Arterio-Sclerosis
Due to (b) Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify two)
(e) Means of injury

23. Signature J S Harding M. D.
Address 3805 Belair Rd Date signed Oct 27/48

VS 150

H98409 ✓ X G68081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr Geo
(c) City or town Greenbelt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 A Crescent Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille [redacted] Shadle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Bert -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-96

8. AGE: Years	Months	Days	If less than one day
52	0	13	hr. min.

9. Birthplace Utah
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Carl Anderson
13. Birthplace ?

MOTHER
14. Maiden Name Christina Jacobson
15. Birthplace ?

16 (a) Informant Friends
(b) Address

17 (a) Burial (b) Date thereof 10 30 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Hyattsville Md.

18 (a) Funeral director Wm. J. F. Hines
(b) Address 2201 14th St N.W. Washington D.C.

19 OCT 29 1948 (b) Huntington Williams, M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Oct 28 1948 and that I last saw h[redacted] alive on Oct 28 1948.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Extensive carcinomatosis	
Due to Carcinoma of cervix	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 20th October
Major findings of operation: Extensive carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Watt
Address Johns Hopkins Hospital Date signed Oct 28 1948

VS 133

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 68082 Registered No. 157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Elmira (If outside city or town limits, write RURAL and give town)
(d) Street No. 379 Warwick St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cynthia Strauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-8-46

8. AGE: Years	Months	Days	If less than one day
2	4	20	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Strauss
13. Birthplace N. Y.

MOTHER
14. Maiden Name Ramona M. Hall
15. Birthplace N. Y.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory, Location Syracuse, N. Y.

18 (a) Funeral director John A. Mitchell & Son Inc
(b) Address 1900 Eutaw Place

19 OCT 29 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948, at 4.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1948, to 10-28 1948, and that I last saw her alive on 10-28 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Angiocardiography with Sudden

Due to Accident

Other Conditions Pulmonic Stenosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Cohen M. D.
Address John Hopkins Hosp Date signed 10-29-48

VS 139

668083

BC-48-23317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

668083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md newborn (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Conwall Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Church Home & Hospital (Town, county, and state)
10. Usual Occupation newborn
11. Industry or business

FATHER
12. Name LLOYD OLIVER
13. Birthplace Virginia

MOTHER
14. Maiden Name VIRGINIA MILLER
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address 406 S. Conwall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct. 29-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John B Connelly
(b) Address 410 Eastern Ave

19 OCT 29 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948 at 10:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1948 to Oct. 28 1948. and that I last saw him alive on Oct 28 1948.

Immediate cause of death	Duration
Hemorrhage	
Due to Bilateral adrenal hemorrhage	
Due to Left pneumothorax	
Other Conditions Rt. upper lobe atelectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard M. Garrett
Address Church Home & Hosp Date signed 28 Oct 48

VS :53

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Age is especially important. Items marked * are optional. Items marked ** may be correctly supplied.

G68084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 ✓ Registered No. G68084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Presbury St.
(c) Hospital or institution: 15.06

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Presbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD A. LONG. ✓

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. none.

4. Sex: male. | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October-15-1875

8. AGE: Years 73 | Months 0 | Days 11 | If less than one day: hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Book Keeper.

11. Industry or business

FATHER
12. Name Otto Long.
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Michael.
15. Birthplace Germany.

16 (a) Informant Mrs. Mildred Mueller.
(b) Address 2908 Presbury St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 29-48. (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 OCT 29 1948 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 26- 1948. at 9.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1948. to Oct 26 1948.
and that I last saw him alive on Oct 26 1948.

Immediate cause of death Lober pneumonia

Due to

Due to

Other Conditions Chronic Cardio Ds, Anemia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett D. Kelly M. D.
Address 734 Poplar St Date signed 10-29-48

V S 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

68085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G68085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 10-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Sr. M. Maurelian Walter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1898

8. AGE: Years	Months	Days	If less than one day
50	5	13	hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Geo. Walter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Anna Obach
15. Birthplace Germany

16 (a) Informant Sr M Rosaria
(b) Address 901 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Gen Mass Frankstown

18 (a) Funeral director Chas M Frankstown
(b) Address 611 W Lafayette Ave

19 (a) Oct 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1948 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948, to 10-28-1948, and that I last saw her alive on 10-28 1948.

Immediate cause of death Acute Cardio-Respiratory Failure — Duration

Due to Uremia

Due to Carcinoma of left breast (Operated on 5yrs ago) with metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Clyde D. Thomas, M.D.
Address Mercy Hospital Date signed 10-28-48

VS 150

68086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital nb 04
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Jenney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred W Myers

3 (b) If veteran, name war: Spanish Amer.
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12. 1876

8. AGE: Years: 72 | Months: - | Days: 16 | If less than one day: hr. min.

9. Birthplace: Bal Co. Md. (Town, county, and state)

10. Usual Occupation: Plumber - Retired

11. Industry or business

FATHER
12. Name ? Myers
13. Birthplace Balto Md

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Balto Md.

16 (a) Informant: Mrs. Wm Hostetter
(b) Address: 15 S. Janney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory: Bal Co Nat Cem
Location: Baltimore

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St Paul St

19 OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948 at 7:05 M

21. I certify that I took charge of the remains described above, held an Exg & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelleher M.D.
Medical Examiner.
Date signed Oct 28, 1948

68087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Gough St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos. or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Gough St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Foster

3 (b) If veteran, name war: World I.

3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 2-1894

8. AGE: Years: 54 | Months: 2 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Glen Burnie Md (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Charles Foster
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Watts
15. Birthplace: Md.

16 (a) Informant: Margaret Andros
(b) Address: 2030 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-1-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Cem.
Location: Baltimore

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St Paul St

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1948, at 10:30 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William J Helfrich M.D. Medical Examiner.
Date signed Oct 28, 1948

G68088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. G68088

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves

(c) Hospital or institution: St. Agnes Hospital No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23/4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 210 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Nan B. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. 228-12-9788

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Claude J Brown

6 (c) If divorced, give date years

7. Birth date of deceased (mo., day, yr.) Feb 3 1884

8. AGE: Years 62 | Months 7 | Days 29 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Ford (deceased)

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Mary Jacobs (deceased)

MOTHER 15. Birthplace Md

16 (a) Informant Claude J Brown

(b) Address 210 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30-48 (month) (day) (year)

(c) Cemetery or crematory Chester Cem

Location Chestertown Kent Co Md

18 (a) Funeral director Edward Foulon

(b) Address 2223 W Baltimore Blvd

19 (a) (b) Huntingtown Williams, M.D. Registrar

Date received OCT 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1948 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-48 to 10-27-48

and that I last saw her alive on 10-27-48

Immediate cause of death Cardio-respiratory failure — Duration

Due to Pneumonia - Contusion

Due to

Other Conditions Chronic bronchitis contusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Sidney Johnson Vansant Jr. M.D. M.D.

Address St. Agnes Hospital Date signed 10/27/48

68089 BC-48-15126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. 68089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital W 7-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5803 Clearspring Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLETA FRAINIE (infant) CORRIGAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1948

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Henry Corrigan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Cleta Frainie
15. Birthplace Baltimore, Md.

16 (a) Informant: James H. Corrigan, Jr.
(b) Address 5803 Clearspring Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director H.W. Mears & Son
(b) Address 805 N. Calvert St.

OCT 29 1948 (Date rec'd by registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 4.30 PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation due to Obstruction of bronchi due to aspiration of vomitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 10/28/48

VS 151

68090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 68090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Ensor Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Ensor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Loveday

3 (b) If veteran, name war: World I War

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Charles Loveday
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Dashields
15. Birthplace Maryland

16 (a) Informant: Emma Browne
(b) Address 1613 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month, day, year)
(c) Cemetery or crematory Balto. National
Location 5501 Frederick Ave.

18 (a) Funeral director Joseph B. Lock, Jr.
(b) Address 1364 N. Central Ave

19 (a) OCT. 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 27, 1948, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner)
Date signed 10-28-48

VS 151

G68091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C ✓ Registered No. G68091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 13 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNIE ROBERTA BOSWORTH

3 (b) If veteran, name war

3 (c) Social Security Account No. 299-05-2614

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Wilbur McKnew Bosworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	✓✓	hr. min.

9. Birthplace: Kennedyville, Maryland (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: Linen Thread Co., Inc.

FATHER
12. Name: Robert Loud
13. Birthplace: Caroline Co., Md.

MOTHER
14. Maiden Name: Mary Jane Yeates
15. Birthplace: Delaware

16 (a) Informant: Mr. J. Alfred Bosworth
(b) Address: 2036 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Baltimore, Maryland

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fat embolism due to multiple fractures

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 13 ✓
(a) Date of injury Oct. 25/48 6:15 P.M.
(b) Where did injury occur? North Ave. & Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto.

23. Signature: Emil L. Kyle M.D. Medical Examiner.
Date signed 10/28/48

Please write plainly, especially important, regarding: please write the causes of death clearly and legibly.

8092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 68092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Bolton St.
(c) Hospital or institution: 1401
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRISON BRENT

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 212-01-1552

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Louise Brent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 16, 1882

8. AGE: Years	Months	Days	If less than one day
66	4	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name Hugh Brent
13. Birthplace The Plains, Va.

MOTHER
14. Maiden Name Sarah Bull
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary L. Brent
(b) Address 1721 Bolton St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948 at 1:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Oct. 1948 to 28 Oct. 1948.
and that I last saw him alive on 27 Oct. 1948.

	Duration
Immediate cause of death Uremia	17 days
Due to Nephritis & Hypertension	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Lockard M. D.
Address 802 Cathedral St. Date signed 29 Oct, 1948

VS 150

668093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

Registered No. 668093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Newington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude S. Nye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth McCafferty

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1906

8. AGE: Years 42 (est) | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Gloucester County, (Va.) Va. (Town, county, and state)

10. Usual Occupation Sales-manager

11. Industry or business Talbot Motors

FATHER
12. Name Louis B. Nye
13. Birthplace Gloucester County, Va.

MOTHER
14. Maiden Name Eleanor Fox
15. Birthplace Gloucester County, Va.

16 (a) Informant Mrs. Elizabeth McC. Nye
(b) Address 705 Newington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Blvd. at Dorsey, Md.

18 (a) Funeral director John O. Mitchell & Son Inc
(b) Address 1900 Eutaw Place, Balto., Md.

OCT 29 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948, at 9:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 10/28/48

68094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Carroll Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Carroll Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth P. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1770

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1898

8. AGE: Years	Months	Days	If less than one day
50	6	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation re-cutter

11. Industry or business B.V.D. Corporation

FATHER
12. Name James E. Fields
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Virginia Hennenberger
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Marjorie Jurkewitz
(b) Address Baltimore, Maryland

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1946 to 10/27 1948, and that I last saw h[illegible] alive on 10-27 1948.

Immediate cause of death: Carcinoma of Ovary — Duration: 2 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 5, 1948

Major findings of operation: Carcinoma of ovary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Unlock, Jr. M.D.
Address 1227 Wash Blvd Date signed 10-29-48

VS 150

68095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Bonaparte Ave
(c) Hospital or institution: 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Bonaparte Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bonhage.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Herman Bonhage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1859

8. AGE: Years 89 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name — Bonhage
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mr. Bonhage
(b) Address 1041 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St

19 (a) OCT 29 1948 (Date rec'd by registrar)
(b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 2.09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Oct 27 1948, and that I last saw her alive on Oct 26 1948.

Immediate cause of death
Bronchopneumonia — Duration 10 days
Myocardial failure — Oct 1/48
Due to arteriosclerosis.

Due to —

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9-08
(a) Accident, ~~suicide, or homicide~~ accident
(b) Date of occurrence Oct 11 1948 at 5:30 P.M.
(c) Where did injury occur? Bath City Md.
(City or town) (County) (State)
(d) Did injury occur about home, ~~on farm, industrial place, in public place~~? Home - Sitting room While at work? No.
(Specify type of place)
(e) Means of injury Fracture suspected with Left femur

23. Signature Jno F. Hemmeter M.D.
Address 722 20 Kenwood Ave Date signed Oct 25 48

Tripped - fell in room - falling on left side

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

G68096

G68096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. AB-124110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Gerland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Wekenman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years 75 or ?? | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ? none

11. Industry or business

FATHER
12. Name Hugh Cox
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosana McClend
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 19 48 at 10.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 19 48 to 10-27- 19 48. and that I last saw h or alive on 10-27- 19 48

Immediate cause of death: Cerebrovascular accident — Duration: 1 week

Due to

Due to

Other Conditions: pulmonary infarction — Duration: 1 Day
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Reichold, M.D.
Address Balto City Hosp. Date signed 10-28-48

VS 150

Burial ✗

68097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1938 Registered No. 68097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 N. Asquith St.
(c) Hospital or institution: At home 10-31
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Asquith ST (If rural give location)
(e) Citizen of foreign country? NO Yes or No
If yes, name country

3 (a) FULL NAME William NAUMANN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife LOUISA NAUMANN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1878

8. AGE: Years 70 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation MARITIME POLICE

11. Industry or business

FATHER
12. Name JOHN NAUMANN
13. Birthplace MD.

MOTHER
14. Maiden Name MARY SPRICK
15. Birthplace GERMANY

16 (a) Informant MRS LOUISA NAUMANN
(b) Address 1004 N. ASQUITH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/1/38 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location BALTIMORE MD

18 (a) Funeral director ULLRICH FUNERAL HOME
(b) Address 2006 ORLEANS ST.

19 (a) OCT 29 1938 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1938, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 1937 to October 28 1938, and that I last saw h IM alive on October 28 1938

	Duration
Immediate cause of death CARDIAC FAILURE	1 DAY
Due to CHRONIC MYOCARDITIS & MYOCARDIAL DEGENERATION	4 YEARS
Due to ARTERIOSCLEROSIS	4 YRS PLUS 3 YRS.
Other Conditions Senile dementia mild (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 10/29/38

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 68098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Druid Hill Ave.
(c) Hospital or institution: 14-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Goode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1897

8. AGE: Years 51 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles L. Goode
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Lora Bundy
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Mary Goode (mother)
(b) Address 2023 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Oct 29 1946 (Date received by Registrar) (Huntington Williams M.D.) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1946 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/46 to 10/28/46, and that I last saw h[illegible] alive on 10/28 1946.

Immediate cause of death Cerebral-Apoplexy
Due to Paralysis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Ben R. Slutts M. D.
Address 239 Druid Hill Ave. Date signed 10/29/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Dud[illegible] St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH CAMPBELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	7	—		

9. Birthplace Laborer (Town, county, and state) West Moreland Co. Va.
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Campbell
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Johnson
15. Birthplace Va.

16 (a) Informant Walter Garner
(b) Address 33 E. Sharpnack St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pinkman St

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 3 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-7 1948 to 10-25 1948, and that I last saw h[illegible] alive on 10-25 1948

Immediate cause of death: Subarachnoid Hemorrhage — Duration 12 hrs

Due to: Hypertension & Arteriosclerosis Cardiovascular Disease — Duration years

Due to:

Other Conditions: Syphilis — Duration years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid Hemorrhage

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Newell, M.D.
Address 1213 Light St. Date signed 10-27-48

PHYSICIAN: Underline the cause to which death should be charged statistically.

VS 150

68100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Manhattan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Manhattan Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME W. Lawrence Summers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virginia E. Summers 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1880

8. AGE: Years	Months	Days	If less than one day
68	0	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Florist.
11. Industry or business

FATHER
12. Name John L. Summers
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Roxanna E. Oliver
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Virginia E. Summers
(b) Address 2500 Manhattan ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 W. North ave.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 4-40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 5 1948 to Oct. 27 1948, and that I last saw him alive on Oct. 28 1948.

Immediate cause of death	Duration
Carcinoma Entire lung with throat involvement	10 mo.
Due to Environment	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 5/48
Major findings of operation: Epidermoid carcinoma left lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. Signature Vernon C. Wantz M.D.
Address 2501 Manhattan Ave. Date signed 10/28/48

VS 150

88101

BALTIMORE CITY HEALTH DEPARTMENT

B.C. 48-23979 CERTIFICATE OF DEATH 159

Registered No. 168101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town White Hall, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Baublitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 27, 1948

8. AGE: Years	Months	Days	If less than one day
		one	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charles Baublitz
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Gertrude Almony
15. Birthplace Parkton, Md.

16 (a) Informant Gertrude Baublitz
(b) Address White Hall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory D. Yeagough
Location Harford Co. Md

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) OCT 30 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1948, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948, to 10/28 1948, and that I last saw her alive on 10/28 1948.

Immediate cause of death
Convulsion
Asphyxia
Due to unknown

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P.A. Peterson M. D.
Address University Hosp Date signed 10/28/48

VS 150

161a

68102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Y 68102 Registered No. 52 L

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 105 days
(e) Length of stay in Baltimore (yrs., mos., or days) 105 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. 5th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS ALBERT CUNHA

3 (b) If veteran, name war USA- 1921

3 (c) Social Security Account No. 199-01-4652

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Mar

6 (b) Name of husband or wife Ella Cunha

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1896

8. AGE: Years 52 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Portugal (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Seafarer

FATHER
12. Name Manuel Cunha
13. Birthplace Portugal

MOTHER
14. Maiden Name Rosa Costa
15. Birthplace Portugal

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-31-48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) OCT 29 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 1:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 13 1948 to Oct. 26 48 and that I last saw him alive on Oct. 26 1948.

Immediate cause of death
1- Carcinoma of bladder
2- Necrosis and infection of bladder wall
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 yr.

Date of operation March 4, 1948

Major findings of operation: Carcinoma of bladder

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 10/29/48 M. D.

VS 199

X

Please see that every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 68103

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3110 Fleet Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3110 Fleet Street. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lena Schuman Zimek

3 (b) If veteran, name war

3 (c) Social Security Account No. one

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/5/76

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	1			

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business Domestic

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mary Fisher

(b) Address 3110 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.,

(b) Address 403 S. Wolfe Street

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington, Millcreek, Md. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 10/27/ 1948, at 4.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 4 1948 to OCT. 27 1948 and that I last saw her alive on OCT. 27 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 10/4/48

Due to ARTERIOSCLEROTIC, HYPER-

Due to TENSIVE CARDIO-VASCULAR ???

DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Jeff F. Spenza M D

Address 209 E. Chester St. Date signed 10/28/48

VS 150

8:04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 668:04

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 S. Lakewood Avenue
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB C. LUEBBEN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-03-4029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Carrie D'Ambrosia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/24/88

8. AGE: Years	Months	Days	If less than one day
59	10	✓	hr. min.

9. Birthplace Baltimore
10. Usual Occupation Shipping Clerk
11. Industry or business

FATHER
12. Name Chas. Luebben
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Carrie Luebben (wife)
(b) Address 801 S. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road
Lilly & Zeiler, Inc.

18 (a) Funeral director
(b) Address 403 S. Wolfe Street

19 (a) OCT 29 1948 (b) Huntington, Williamsport

MEDICAL CERTIFICATION P

20. DATE OF DEATH 10/ 26/ 1948, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1948 to Oct. 26 1948, and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death	Duration
Chronic mitral regurgitation	?
Due to Chronic myocarditis	10 months
Due to Coronary thrombosis	3 days
Due to Chronic bronchitis, bilat.	?
Other Conditions Arterio-sclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Bromukas, M.D.
J. Benedict Bromukas, M.D.
Address 3037 O'Donnell St Date signed OCT 28 1948

VS 150

668:05

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 668:05

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. Myrtle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice T. Schwatka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Dr. CharlesT.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1883

8. AGE: Years 65 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace: Montgomery County, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Robert Assa Gladmon
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden Name: Augusta Virginia Glover
15. Birthplace: Montgomery County, Md.

16 (a) Informant: Mrs. Dorothy Kellanr
(b) Address: Crisfield, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-48 (month) (day) (year)
(c) Cemetery or crematory: Sunny Ridge Memorial Park
Location: Crisfield, Maryland

18 (a) Funeral director: Bradshaw Funeral Parlors
(b) Address: Crisfield, Maryland

19 (a) [illegible] 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948 at 4:20A. M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial plant, in public place? While at work?
(d) Means of injury

23. Signature Ashley R. Davis M.D.
Medical Examiner.
Date signed 10-29-48

668:06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668:06

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 E. Balt. St
(c) Hospital or institution: 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Riefner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis Riefner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 21, 1861

8. AGE: Years 87 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Bleitsman
13. Birthplace Germany

MOTHER
14. Maiden Name ? [illegible]
15. Birthplace Germany

16 (a) Informant Mrs Lillian Dunlap
(b) Address 3009 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director John A. Morar
(b) Address 3060 E. Balt St.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948, at 12:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Oct 28 1948, and that I last saw HER alive on Oct. 14 1948.

Immediate cause of death: Hypostatic pneumonia — Duration: 4 wks
Due to
Due to
Other Conditions Epithelioma nose
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. MacMenamin M. D.
Address 2911 E. Balt. St. Date signed Oct 29, 1948

VS 150

111 c

Certificate Corrected 11-19-49.

G68:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G68:07

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital (D.O.A.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A. Copenhaver

3 (b) If veteran, name war ********

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Catharine R.

6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) April 30, 1894

8. AGE: Years 54 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Sunbury, Pa.
(State, county, and state)

10. Usual Occupation Designing Eng.

11. Industry or business Crown Cork & Seal

FATHER
12. Name Anson Copenhaver
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Jane Mutschler
15. Birthplace Pa.

16 (a) Informant: Mrs. Catharine Copenhaver
(b) Address 3405 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (mo.)

(c) Cemetery or crematory Sandy Mount M-Church
Location Sandy Mount, Carroll Co. Md.

18 (a) Funeral director LORING BYERS
(b) Address 5005 Park Heights Ave.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/48 19 .. 8:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy on thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 10/27/48

VS 181

68108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. 68108

68108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-18
(c) Hospital or institution Md. Gen'l Hosp DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and the town)
(d) Street No. 5224 Wilton Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl S. Hart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret L. (Owen)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1892

8. AGE: Years 56 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Blizzardville, Harford Co. Md
(Town, county, and state)

10. Usual Occupation Tapping Finisher

11. Industry or business Lombaert & Bench

FATHER
12. Name Harry C. Hart
13. Birthplace Savannah, Ga.

MOTHER
14. Maiden Name Anna E. Street
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Margaret L. Hart
(b) Address 5224 Wiltons Hgts Ave

17 (a) Burial (b) Date thereof 10-30-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olive
Location Randallstown Md

18 (a) Funeral director Leroy Boyce
(b) Address 5505 Park Heights Ave

19 OCT 29 1948 Registrar Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelbach M.D.
Medical Examiner.

Date signed Oct 28, 1948

VS 131

2815 Mayne Falls Md.

668:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 668:09

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 W. North Ave.
(c) Hospital or institution:
15.66
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 W North
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B Reed

3 (b) If veteran, name war ~

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sabilla Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7 1860

8. AGE: Years 88 | Months 8 | Days 20 | If less than one day hr. min. 19

9. Birthplace Fredericksburg Pa.
(Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER
12. Name Franklin Reed
13. Birthplace Fredericksburg Pa

MOTHER
14. Maiden Name Lydia Bricker
15. Birthplace Fredericksburg Pa.

16 (a) Informant Mrs. Frank B Reed
(b) Address 2813 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 30 - 48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director E Ellsworth Armacost
(b) Address 3914 Liberty Heights Ave

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948 to Oct 1948 and that I last saw h im alive on Oct 26 1948

Immediate cause of death Acute nephritis é uremia — Duration 2 weeks

Due to Arteriosclerotic Cardio-Vascular disease — ?

Due to

Other Conditions Chronic Nephritis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Daniel K Robinson M. D.

Address 2825 Garrison Blvd Date signed 10/29/48

Daniel K. Robinson

VS 152

68110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-a

68110 Registered No.

Please write plainly. Use ink. Do not use pencil. Do not fold. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Church St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Church St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B. Mallonee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Cecelia
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr) May 26, 1895

8. AGE: Years	Months	Days	If less than one day
63	5	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Brice Mallonee
13. Birthplace Md

MOTHER
14. Maiden Name Sallie Martin
15. Birthplace Virginia

16 (a) Informant Mrs Marie Mallonee
(b) Address 1525 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948, at 12 N A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to Oct. 26 1948. and that I last saw him alive on Oct. 26 1948.

Immediate cause of death Pulmonary Hemorrhage — Duration 1 hour

Due to Metastatic Malignancy to Lungs

Due to Carcinoma of Rt. Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Rt Kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Mallon
Address 320 Dalrymple Ave Date signed 10/29/48 M.D.

VS 15)

G68111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 15

Registered No. G68111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Payson St.
(c) Hospital or institution: 16-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conway Shepard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Maried

6 (b) Name of husband or wife Mrs. Mollie Shepard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 31 1892

8. AGE: Years	Months	Days	If less than one day
55	9	25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Schauffuer
11. Industry or business

FATHER
12. Name Allen Sheapard
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Latten
15. Birthplace Virinia

16 (a) Informant Mrs. Mollie Shepard
(b) Address 1013 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948 to Oct. 26 1948. and that I last saw him alive on Oct 26 1948

Immediate cause of death Cancer of Stomach — Duration ?

Due to

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 844 N Carey St. Date signed 10/28/48

VS 150

68112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166 Registered No. 68112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital 3-0 V
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christopher Gre[illegible]
13. Birthplace Virginia

MOTHER
14. Maiden Name Hester ?
15. Birthplace Gloster Co., Va.

16 (a) Informant: Arthur Green (brother)
(b) Address 1114 E. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-48 (month, day, year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elmer O. Wilson
Address 1100 Boundary Ave

19 OCT 29 1948 (Date rec'd by registrar) Hennington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948 at 9:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of brain

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-10-48 1:05 P. M.
(b) Where did injury occur? In Front of 2100 Colfax Way, Dundalk, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work) no
(d) Means of injury Firearms

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 10/29/48

VS 151

68113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 day (Present admission)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 3625 Kimble Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Segwalt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Segwalt

6 (b) Name of husband or wife Lucie E. [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1887

8. AGE: Years 61 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Accountant (Retired)

11. Industry or business Alemite Co. of Md.

FATHER 12. Name John Segwalt
13. Birthplace N. Y.

MOTHER 14. Maiden Name Elizabeth Hartel
15. Birthplace N. Y.

16 (a) Informant Mrs. Lucie E. Segwalt
(b) Address 3625 Kimble Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Huntington Williams, Mgr.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 11 53 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1948 to Oct. 28 1948 and that I last saw h/ alive on Oct. 28 1948

Immediate cause of death Cachexia — Duration

Due to Osteogenic sarcoma of Right ilium with Diss generalized metastasis — 6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 10-28-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct name, address and other information should be carefully supplied.

VS 150

G68114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68114

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The name, year or information should be carefully supplied. T

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Prospect Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLSWORTH THOMAS MEAD

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widow

6 (b) Name of husband or wife: Lavinia Augusta Mead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	5	hr. min.

9. Birthplace: Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation: Toolmaker
11. Industry or business

FATHER
12. Name: Ellsworth Mead
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Josephine Clark
15. Birthplace: N. Y.

16 (a) Informant: Miss Grace E. Mead
(b) Address: 4504 Prospect Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1948 (month) (day), (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Functioning for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/48 19 . at 12:07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22/48 19 . to 10/29/48 19 . and that I last saw h/m alive on 10/29 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to cerebral edema	
Due to Aortic stenosis due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M. D.
Address W. Balto Hospital Date signed 10/29/48

VS 150

68115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

Registered No. 68115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Restman St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME McGowan, Irene
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Morrison McGowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	18	hr. min.

9. Birthplace Woodstock, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Gustavus Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. Frost
15. Birthplace Maryland

16 (a) Informant John R. Brown
(b) Address 9 Yorkway, Dundalk

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location: Ellicott City, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948 at 7:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-21 1948 to 19 and that I last saw her alive on 10-28 1948

Immediate cause of death: Cerebral Thrombosis — Duration 4 days
Due to: Hypertensive Arteriosclerotic Cardiovascular Disease — Duration years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cerebral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward R. Powell M.D.
Address 1213 Light Street Date signed 10-29-48

VS 150

668316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 668316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Joseph~~ E. Baggett

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 217-22-2231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 18, 1927

8. AGE: Years	Months	Days	If less than one day
21	4	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Traffic Clerk
11. Industry or business S. Shapiro & Sons

FATHER
12. Name John H. Baggett
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Bertha M. Griffith
15. Birthplace Baltimore, Maryland

16 (a) Informant John V. Baggett
(b) Address 3530 Hickory Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1948 to Oct 28 1948, and that I last saw h[illegible] alive on Oct 28 1948.

Duration

Immediate cause of death Cardiac failure
Due to Rheumatic C-V disease mitral stenosis (Enter but one)
Due to Acute left sided failure
Other Conditions pneumonitis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Verrill Jr. MD
Address St. Agnes Hospital Date signed M. D. 10/29/48

X

68117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S Norris St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. WILLIAM A. BROMWELL

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary Bromwell
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 11-30-72

8. AGE: Years	Months	Days	If less than one day
75	10	29	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Hotel business

FATHER
12. Name Robert Bromwell
13. Birthplace Md.

MOTHER
14. Maiden Name Melinda Wolford
15. Birthplace Md

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore Md
18 (a) Funeral director J. H. Butler & B. M. Walter
(b) Address Pratt & Stricker
19 (a) OCT 29 1948 (Date rec'd by registrar) Burlington Williams Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1948 at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1948 to 10-29-1948 and that I last saw him alive on 10-29-1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Thrombosis	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn P. Judd M. D.
Address Mercy Hospital Date signed 10-29-48

Allyn P. Judd. ×

VS 189

68118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 d Registered No. 68118

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1000 Eutaw Avenue

(c) Hospital or institution: Jenkins Memorial Hospital 29 ward

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos. 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 317 S. Augusta Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rose Emma Neville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph E. Neville

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN. 29-1873

8. AGE: Years	Months	Days	If less than one day
75	9	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business At Home

FATHER 12. Name Ferdinand A Bonhage Bonhage

13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Ebute

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ford A. Neville, Son

(b) Address 155 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director C. B. Wisbert & Son

(b) Address 1301 Eutaw Place 17

19 OCT 29 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948 at 8 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/1948 to 10/26 1948, and that I last saw h alive on 10/26 1948.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Acute Coronal Thrombosis

Due to Hypertensive C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward L. Cass Jr. M. D.

Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G68119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68119

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same as above
(a) State Md. (b) County Curtis Bay
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Orchard Beach (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Carbary

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 129-05-0964

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeanette (wife)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9-1921

8. AGE: Years: 27 | Months: 4 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Conn. (Town, county, and state)

10. Usual Occupation: Installator

11. Industry or business

FATHER
12. Name: Thomas Carbary
13. Birthplace: Conn

MOTHER
14. Maiden Name: Helena Fagan
15. Birthplace: Conn

16 (a) Informant: Jeannette Carbary (wife)
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 30/48 (month) (day) (year)
(c) Cemetery or crematory: Bello. National Cemetery
Location: Frederick Ave.

18 (a) Funeral director: Krauze Funeral Home
(b) Address: 1216 E. Charles St.

19 (a) Oct 29 1948 (b) Huntington Williams, MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-26-1948, at 3 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1948 to 10/26 1948 and that I last saw him alive on 10/26 1948.

Immediate cause of death: Acute Failure

Due to: Acute Intestinal Hemorrhage

Due to: Cirrhosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Cirrhosis, Fatty infiltration

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Michael F. Raimondo, M.D.
Address: Spring Grove Hosp. Date signed 10/29/48

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68120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 68120

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address RAYNOR AND DUKELAND AVE.

(c) Hospital or institution: WEST BALTIMORE GENERAL HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2DAYS

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTIMORE

(c) City or town OELLA

(If outside city or town limits, write RURAL and give town)

(d) Street No. GRANITE HILL (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME CLARA VIRGINIA CAIN

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife RALPH CAIN

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) APRIL 30, 1899

8. AGE: Years	Months	Days, if	If less than one day
49	5	27	hr. min.

9. Birthplace STEPHEN'S CITY, VIRGINIA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name MORGAN TEVAULT

13. Birthplace STEPHEN'S CITY, VIRGINIA

MOTHER

14. Maiden Name MARGARET WHITE

15. Birthplace STEPHEN'S CITY, VIRGINIA

16 (a) Informant RALPH CAIN

(b) Address OELLA, MARYLAND

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Johns Cem. Location Ellicott City, Md.

18 (a) Funeral director Ralston Stone

(b) Address Ellicott City, Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/48 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26/48 19.. to 10/28/48 19.., and that I last saw her alive on 10/27/48 19.. 1PM

Immediate cause of death Heart failure of unknown nature

Due to Causes completely unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration: over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide None

(b) Date of occurrence M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. P. Young

Address West Balto. Bch. Hosp. Date signed M. D. 10/28/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

68121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178

Registered No. 68121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMETT A. RAMSEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	13	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ramsey
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Hillman
15. Birthplace Va.

16 (a) Informant Nellie E. Williams
(b) Address 607 Bancroft Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Com.
Location Richmond Virginia

18 (a) Funeral director John L. Miller
(b) Address 2435 E. Oliver St.

1948 OCT 30 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 6:15 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Illuminating gas
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27/48 approx. 5 P. M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas—Oven burner on but unlit

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 10/28/48

VS 151

68122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Madison ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mary Watson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 2-1890

8. AGE: Years	Months	Days	If less than one day
58	5	5	hr. min.

9. Birthplace Salisbury Md (town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER	12. Name Alexander Watson
	13. Birthplace Md
MOTHER	14. Maiden Name Minnie Phillips
	15. Birthplace Md

16 (a) Informant Mary Watson
(b) Address 2117 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm J Jackson
(b) Address 916 Druid Ave

19 OCT 30 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Oct 27 1948. and that I last saw him alive on Oct 27 1948.

Immediate cause of death Cardio-Nephritis (Autopsy) — Duration 10 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. A. Julian M. D.
Address 511 N. Salisbury Date signed 10/29/48

VS 150

68123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 09
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS KLUG

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 25 1874

8. AGE: Years	Months	Days	If less than one day
74	2	4	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant R.E. Dressell
(b) Address 3918 Ednor Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St. Baltimore, Md

OCT 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to 29 Oct 1948, and that I last saw h[illegible] alive on 22 Oct 1948.

Immediate cause of death: Cardio Vascular Disease
Aortic Stenosis
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1
2
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfine M.D.
Address 714 E. Preston St Date signed 29 Oct 48

VS 150

G68124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 2 d

Registered No. G68124

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2007 Belair Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 Belair Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jacob Dieter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, ~~divorced~~
M	W	Widowed

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10-1867

8. AGE: Years	Months	Days	If less than one day:
80	11	18	hr. min.

9. Birthplace Rutty Hill Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Charles Dieter

13. Birthplace Rutty Hill Baltimore

MOTHER

14. Maiden Name Mary Smith

15 Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director Jos F Harrison & Son

(b) Address 3001 Pinkney ave

19 (a) OCT 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 28 - 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25- 1940, to 10-27- 1948, and that I last saw him alive on 10-27- 1948.

Immediate cause of death	Duration
Pulmonary Oedema	24 hrs.
Due to Valvular Heart Disease	8 years
Due to Generalised arterio-sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melton C. Lang

Address 2117 Belair Rd Date signed 10-28-48 M. D.

VS 150

X

668125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 668125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 N. Arlington Ave
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Brent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1888.

8. AGE: Years	Months	Days	If less than one day
60	—	—	hr. min.

9. Birthplace Fayetteville, N.C. (Town, county, and state)

10. Usual Occupation Ice Dealer.

11. Industry or business

FATHER
12. Name
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace N.C.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Oct. 28 1948 (b) Embalmed by Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1948, at 2 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 1948, to 10-27 1948, and that I last saw him alive on 10-27 1948.

Immediate cause of death, Uremia
nephritis chronic

Due to

Due to

Other Conditions Malignant hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 10-27-48

VS 190

68126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

926 Registered No. 68126

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-07
(c) Hospital or institution:
Hosp Women Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Miles Ave -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Lillie May Snoouffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife John A Snoouffer
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan - 17 - 1907

8. AGE: Years	Months	Days	If less than one day
41	9	10	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Haberle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie Cooper
15. Birthplace Baltimore

16 (a) Informant Lillie M. Snoouffer
(b) Address 2827 Miles Ave

17 (a) Burial (b) Date thereof Oct 30/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden

18 (a) Funeral director Chas L E Lehmann Jr.
(b) Address 3615-17 Chestnut Ave

19 OCT 30 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 27 1948 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 25 1948 to Oct 27 1948 and that I last saw h[illegible] alive on Oct 27 1948

Immediate cause of death Cardiac Decompensation — Duration
Due to Mitral Stenosis
Due to Rheumatic Heart Disease — 15 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mitral stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Hosp Wom Md Date signed X - 27 - 48

VS 190

68127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68127

ES-52529

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 853 W. Fayette St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Michel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? 1883

8. AGE: Years	Months	Days	If less than one day
65?	-	-	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation Sells Pencils

11. Industry or business

FATHER

12. Name Peter Michel (D)

13. Birthplace Newfoundland

MOTHER

14. Maiden Name Mary ? (D)

15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 1 1948 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary Cem

Location Balto. County

18 (a) Funeral director John M. Weber

(b) Address 48 S. Chester Street

OCT 30 1948 (Date rec'd by registrar)

(b) Registrar

Washington Millimet M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 10-13 1948 at 7:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-2- 1940 to 10-13 1948, and that I last saw him alive on 10-13 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr.

Due to: Coronary Sclerosis — 2-3 yr.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Stutzman

Address Balto. City Hosp. Date signed 10-29-48 M.D.

X

G68128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3530 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life--.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry S. Marshall

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Marshall nee Bechtol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1867

8. AGE: Years 80 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sail maker

11. Industry or business Al. Roberts Co.

FATHER
12. Name Robert Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Jones
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Wm. H. Davis
(b) Address 3530 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 19[illegible] at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 19 47 to Oct 25 19 48.
and that I last saw h[illegible] alive on Oct 2, 1947

Immediate cause of death: Coronary thrombosis — Duration 5 days

Due to: Coronary sclerosis

Due to: Chronic arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Bowden

Address 1517 E. North Ave. Date signed 10/27/48 M. D.

VS 150

H. A. Bowden

68:29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

✓ 68:29 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant: "

(b) Address "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Brooklyn, Maryland

18 (a) Funeral director Ralph L. Alves

(b) Address 600 McCulloh St.

19 OCT 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)

Date signed 10-26-48

VS 151

68130 BC-C68404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Pennsylvania Avenue
(c) Hospital or institution:
17-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Pennsylvania Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUSTACE NATHANIEL HERRINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1946

8. AGE: Years	Months	Days	If less than one day
1	10	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Leo Herrington
13. Birthplace South Carolina

MOTHER
14. Maiden Name Beatrice Weldon
15. Birthplace Washington D.C.

16 (a) Informant Leo Herrington
(b) Address 1214 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-46 (month, day, year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 30 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1946, at 7.55 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/26/46

VS 151

68131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68131

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Street

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks

(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County —

(c) City or town Henderson (If outside city or town limits, write RURAL and name town)

(d) Street No. 234 South Main St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. James J. Wiseman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Alene Wiseman 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-27-1895

8. AGE: Years	Months	Days	If less than one day
52	0	3	hr. min.

9. Birthplace KENTUCKY (Town, county, and state)

10. Usual Occupation Oil Field Worker

11. Industry or business

FATHER 12. Name Mr W.M. Wiseman

13. Birthplace Kentucky

MOTHER 14. Maiden Name Mary Carroll

15. Birthplace Kentucky

16 (a) Informant wife

(b) Address 234 South Main St, Henderson

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory Compton, Location Compton, Kentucky

18 (a) Funeral director Wm Cook Sons

(b) Address 617 St Paul St Huntington West Virginia

19 (a) OCT 30 1948 (b) Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 19 48 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 19 48 to Oct 30 19 48, and that I last saw h alive on Oct 30 19 48

Immediate cause of death Cardiorespiratory failure — Duration 5 days.

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-16-48

Major findings of operation: Metastases and carcinoma

of autopsy Bx proved at abdominal exploration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Solomon P. Grove, M.D.

Address Union Memorial Hospital Date signed 10/30/48

VS 150

068132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 068132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Brunt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Loretta Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1897

8. AGE: Years	Months	Days	If less than one day
51	3	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Produce Dealer.
11. Industry or business

FATHER
12. Name John Hamilton.
13. Birthplace Hot Spring W. Va.

MOTHER
14. Maiden Name Mary J. Hughes.
15 Birthplace Baltimore, Md.

16 (a) Informant Elmer Hamilton.
(b) Address 802 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 1 1948 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director Mrs Katye R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received by registrar OCT 29 1948 (b) Registrar Huntington Williams Mgr.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948, at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1948 to Oct 28 1948
and that I last saw him alive on 19

Duration
One Week
1
0
0

Immediate cause of death Acute Broncho-Pneumonia
Due to
Due Bronchial Asthma one year
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Timothy Shelton M. D.
Address 230 S. Chapel St. Date signed 10/29/48

AB-124113 168133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

013 K

Registered No. 168133

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days

(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 433 N. ~~Exeter~~ Exeter St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard Sutton (Willard O. Sutton)

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ? June 25, 191

8. AGE: Years	Months	Days	If less than one day
33	4	4	hr. min.

9. Birthplace West Virginia (Harrison Co.)
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

MOTHER / FATHER

12. Name Nathen G. Sutton

13. Birthplace West Virginia

MOTHER

14. Maiden Name Una Kemper

15. Birthplace West Virginia

16 (a) Informant Records, Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory

Location Clarksburg, West Virginia

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.

(b) Address North & Pa. Aves. Balto. 17

19 (a) Filed by registrar Huntington Williams, M.D.

OCT 31 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29- 1948 at 9.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 1948 to 10-29- 1948 and that I last saw h im alive on 10-29- 1948

Immediate cause of death	Duration
(a) Far advanced Pulmonary tuberculosis	7 yr.
Due to	
Due to Tuberculosis of (St. bit) Malnutrition	8 yr. 3 mon.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)

(e) Means of injury —

23. Signature Frank M. Shipley M.D.

Address Balto. City Hosp. Date signed 10-30-48

Court Case ✓ X

668:34

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668:34 Registered No. 164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Randall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DIXIE STERAGO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Anthony Sterago
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1914

8. AGE: Years	Months	Days	If less than one day
33 33	10	24	hr. min.

9. Birthplace Black Creek, N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Anthony John Sterago
(b) Address 103 W. Randall St-West Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Contentnea
Location Wilson, N.C.

18 (a) Funeral director B. L. Hopping & Son
(b) Address Annapolis, Md

19 (a) OCT 31 1948 (Date rec'd by Registrar) (b)

Contentnea Wilson N.C.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 3:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-28-48 at 3:30 P. M.
(b) Where did injury occur? 103 Randall St., Annap. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms

23. Signature Earle Boyle M.D. Medical Examiner
Date signed 10-30-48

X

G68135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. G68135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Academy St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH Lizzie Bell BELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Rumania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David Schwartz
13. Birthplace Rumania

MOTHER 14. Maiden Name Sarah Cohen
15. Birthplace Rumania

16 (a) Informant Beatrice Cohen
(b) Address 107 Botwood Rd. Wilmington, Del.

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Lombardy
Location Wilmington, Delaware

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place.

OCT 31 1948 (Date rec'd by registrar) Wilmington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Oct 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra cranial bleeding

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-30-48 at 12 noon M.
(b) Where did injury occur? Tavern at 1534 Chalgrove Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Lost balance and fell down flight of steps

23. Signature Earl L. Ruzzo M.D. Medical Examiner.
Date signed 30 Oct 48

G68136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 448 G68136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 YR.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 ROLAND AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME (Annie) ANNA E DEVON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) ----------

8. AGE: Years	Months	Days	If less than one day
About 76	--	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name William H. Devon
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ella E. Roney
15. Birthplace Baltimore, Maryland

16 (a) Informant William Devon
(b) Address 6 E. Read Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert St.

19 (a) Nov 21 1948 (Date received by Registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 29 1948 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 15 1947 to OCT 29 1948 and that I last saw [illegible] alive on OCT 28 1948.

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION OCT	29.48
Due to HODGKINS DISEASE	AUG 47.
Due to CHRONIC ARTHRITIS	1948
Other Conditions	

Date of operation AUGUST 1947.
Major findings of operation: HODGKINS DISEASE LYMPH GLANDS OF THE THYROID GLAND
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas T. Edmunds
Address 3013 ST PAUL STREET Date signed OCTOBER 29 1948

BC- 48-3385 G68137 ✓ 160 C G68137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Berger Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ronald Zobig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-22-48

8. AGE: Years | Months | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Zobig
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Kleiner
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial (Park)
Location Washington Blvd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

OCT 31 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948, at 9205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23-1948 to 10-29 1948, and that I last saw him alive on 10-29 1948.

Immediate cause of death: Meconium Ileus — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 23, 1948

Major findings of operation: Meconium filled bowel

Of autopsy: Peritoneal fluid, enlarged liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Handelsman M. D.
Address The Johns Hopkins Hospital Date signed

668138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

061

668138

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Rayman Ave
(c) Hospital or institution: 26-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Rayman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mollie Schillfarth

3 (b) If veteran, name war: none

3 (c) Social Security Account No. [redacted]

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred J. Schillfarth

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 14, 1901

8. AGE: Years: 47 | Months: 7 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Balto County - Md (Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business:

FATHER
12. Name: John Hoffman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Muller
15. Birthplace: Germany

16 (a) Informant: Frederick J. Schillfarth
(b) Address: 4217 Rayman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Milton Ave Rose Hill

18 (a) Funeral director: Howard N. Bluth Jr.
(b) Address: 6009 Harford Road

19 (a) Nov 1 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947, to Oct 30 1948 and that I last saw h[illegible] alive on Oct 4 1948.

Immediate cause of death: Diabetes — Duration: 2 yrs
Due to: Hypertension — 2 yrs
Due to: Myocardial insufficiency — 3 mos
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature: Edward W. Dunham M. D.
Address: [illegible] Date signed: 10/30/48

VS 150

668139

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH

170c

668139

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 10-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Summerset Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bridge

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1908

8. AGE: Years 40 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (City and state)

10. Usual Occupation Stock clerk

11. Industry or business Sears Roebuck & Co.

FATHER
12. Name Henry F. Bridge
13. Birthplace Germany

MOTHER
14. Maiden Name Anna B. Zintgraf
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna B. Bridge
(b) Address 1021 Summerset Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager Street

19 (a) Date received (by registrar) OCT 31 1948 (Huntington Williams, M.D.) Registrar

VS 15t

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948 at A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Intracranial hemorrhage.
Due to Contusion of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-24-48 at Approx. 4:40 P.M. 9/8
(b) Where did injury occur? Kirk Avenue, 36' south of 22nd Street
(c) Did injury occur at home, on farm, in industrial place, in public place? Public While at work? no
(d) Means of injury Ped. struck by truck

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/28/48

X

668140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1174

Registered No. 668140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Mura St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur O. Link

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-01-0598

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary J. Connelly Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1881

8. AGE: Years 67 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (City, county, and state)

10. Usual Occupation Watchman

11. Industry or business Crown Cork & Seal Co

FATHER
12. Name George Link
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bura
15. Birthplace Germany

16 (a) Informant Mrs. Mary A. Link
(b) Address 715 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Corkran
(b) Address 924 E. Eager St.

19 (a) OCT 23 1948 (date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948, at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 29 1948. and that I last saw h alive on Oct 29 1948.

Immediate cause of death: Pulmonary Edema — Duration: 17 hrs.

Due to Myocarditis, chronic with decompensation — 3 years

Due to Duodenal Ulcer. — 3 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Donaghy M.D.

Address 10 E. Biddle St Date signed 10/29/48

V S 190

Huntington for Williams, MD

68141 ✓ X 68141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 0136

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Retreat Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53-9-26

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write RURAL and give town)
(d) Street No. unknown (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Sheehan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1876

8. AGE: Years	Months	Days	If less than one day
72	?	?	hr. min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual Occupation mental patient - 53 yrs.
11. Industry or business

FATHER
12. Name John Sheehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice O'Keefe
15. Birthplace Ireland

16 (a) Informant The Retreat Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Shawen Memorial Co.
(b) Address 08 W. Fayette

19 (a) Date rec'd by registrar OCT 31 1948 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1930 to Oct. 29 1948, and that I last saw her alive on 10-29 1948.

Immediate cause of death Myocarditis — Duration 4 weeks

Due to

Due to

Other Conditions Fibroid Tuberculosis Mental Deficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Damon P. Adams M. D.
Address 33 W. Madison St. Date signed

VS 180

68142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68142

1. PLACE OF DEATH: Home for Incurables
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-3-15
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander B. Gillespie
3 (b) If veteran, name war
3 (c) Social Security, Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	

6 (b) Name of husband or wife Fanny P. R. Gillespie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1864

8. AGE: Years 84 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Londonderry, Ireland (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business Steamship

FATHER
12. Name William Gillespie
13. Birthplace Londonderry, Ireland

MOTHER
14. Maiden Name Eliza Hyndman
15. Birthplace Londonderry, Ireland

16 (a) Informant Jane L. Adamson, Supt.
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City

19 (a) [illegible] (Signature of registrar) (b) Date received Nov 2 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1943 to 10/29 1948. and that I last saw him alive on 10/28 1948

Immediate cause of death: Spontaneous Pneumothorax — Thoracic — Duration: 30 Hours

Due to: arteriosclerotic Cardio-Vascular Renal Disease — Duration: 10 years

Due to: Carbid Vascular Accident — Duration: 6 years

Other Conditions: Prostatic (Ca.) — Duration: 2 years

Bilateral Inguinal Hernias

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hersperger M. D.
Address 214 Medical Arts Building Date signed 10/29/48

VS 153

G68143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G68143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Crest Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~Same~~ Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Crest Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARSH JAMES

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Married

6 (b) Name of husband or wife Blaine L. James
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) August-11-1885

8. AGE: Years	Months	Days	If less than one day hr.	min.
63	2	18		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Joshua Marsh
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Rebecca Albin
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Ruth J. Wagner (daughter)
(b) Address 2414 Crest Road, City #9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-1-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1

19 (a) ~~Filed~~ Recorded by (Registrar) Huntington Williams M.D. (b) Registrar

~~OCT 31 1948~~

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1946 to Oct 29 1948 and that I last saw her alive on Oct 29 1948

Immediate cause of death	Duration
Carcinoma of Colon with Cerebral Metastases	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/3/48
Major findings of operation: Carcinoma Sigmoid Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 898 W 36th St Date signed 10/29/48

G68144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CERTIFICATION APPROVED BY

Registered No. 186 M 68144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN Ave. AND MADISON ST.
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 N. CALVERT ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA DEAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
90	2	17	hr. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JEREMIAH FISCHER
13. Birthplace PENNA.

MOTHER
14. Maiden Name NANCY (UNKNOWN)
15. Birthplace PENNA.

16 (a) Informant H. CLAY DEAN (SON)
(b) Address 2510 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory
Location Addison PENNA.

18 (a) Funeral director H. H. Williams and Son
(b) Address 805 N. Calvert St.

(a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1948, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/30 1948, and that I last saw her alive on 10/30 1948.

Immediate cause of death CORONARY THROMBOSES — Duration

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Due to

Other Conditions FRACTURE OF LEFT FEMUR
(Include pregnancy within 3 months of death)
Date of operation 10/13
Major findings of operation: FRACT. OF LEFT FEMUR
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT 17 days
(b) Date of occurrence 10/6/48 at M
(c) Where did injury occur? BALTIMORE, MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work? NO (Specify type of place)
(e) Means of injury FELL GETTING OUT OF BED
23. Signature Paul D. Arnold
Address Md. Gen. Hosp. Date signed 10/30/48 (M. D.)

VS 199

TO BE OKAYED BY MEDICAL EXAMINER

Please write the causes of death clearly and legibly.

668145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668145

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 141 S Collington Ave

(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 141 S Collington Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary F Graber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-1889

8. AGE: Years 59 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John F Graber

13. Birthplace Md

MOTHER 14. Maiden Name Anna Sadtler

15. Birthplace Md

16 (a) Informant John F Graber

(b) Address 141 S Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Guy C Talley

(b) Address Catonsville Md

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-26 1948 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May-31 1945 to Oct-25 1948, and that I last saw h[illegible] alive on May-25 1948.

Immediate cause of death: Hypertension

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: —

Duration: 4 yrs. / 3-4 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D Lloyd Johnson M. D.

Address Catonsville Md Date signed 10/30/48

VS 150

Correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G68146 BALTIMORE CITY HEALTH DEPARTMENT G68146 Registered No.

CERTIFICATE OF DEATH

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Pennsylvania
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Penna. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Joffe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Zolman

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Ida Joffe

(b) Address 2325 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Hebrew Cem

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 (a) OCT 31 1948 (b) (Date rec'd by registrar) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1948 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 28 1948 to 10 29 1948 and that I last saw him alive on 10/29 1948

Immediate cause of death Coronary occlusion — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wilson

Address 5771 Park Heights Ave Date signed 10/30/48

VS 153

68147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS BRUTUS Tinsley Coker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GRACE C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): NOV. 4 1884

8. AGE: Years 63 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace: NORTHHAMPTON VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: THOMAS B. COKER
13. Birthplace: NORTH CAROLINA

MOTHER
14. Maiden Name: ANNIE M. AQUIRES
15. Birthplace: VIRGINIA

16 (a) Informant: MRS. GRACE C, COKER
(b) Address: PORTSMOUTH VA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof NOV. 2/48 (month) (day) (year)
(c) Cemetery or crematory: OAK GROVE
Location: PORTSMOUTH VA.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: NORTH & PENN. AVES.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948 at 1:35 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Heyd M.D.
(Attending Physician or Coroner)
Date signed Oct 30, 1948

VS 151

38148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 668148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Elsinor Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr 10 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Elsinor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna Start

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 - 1875

8. AGE: Years 73 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Clerk

FATHER
12. Name John Wesley Start
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester Foreman
15. Birthplace Pa.

16 (a) Informant Mrs. Paulline Harmison
(b) Address 2007 Elsinor Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 / 1 / 48 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Smyrna Delaware

18 (a) Funeral director J. Wells Faries
(b) Address Smyrna, Delaware

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Harry [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948, at 6 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Oct 31 1948 and that I last saw h-r alive on Oct 31 1948.

	Duration
Immediate cause of death Acute dilitation	2 hrs
Due to Myocarditis	about 4 mo.
Due to arterio-sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Riddell, M. D.
Address 2220 Garrison Blvd Date signed Oct 31 1948

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68149

ES-123274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G68149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Montery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Manie Murphy

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 23, 1871

8. AGE: Years	Months	Days	If less than one day
77	0	8	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Conrad Razarenus (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Ottman (D)
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS.
(b) Address 4940 EASTERN AVE.B

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fayette St.

19 (a) NOV 1 1948 (b) Huntington for Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

A
20. DATE OF DEATH 10-31 1948 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948 to 10-31 1948
and that I last saw her alive on 10-31 1948

Immediate cause of death: Cerebrovascular Accident — Duration: 1 mon.
Due to
Due to
Other Conditions Hypertension, arteriosclerotic Heart disease — Duration: 5yrs +
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Redstold M. D.
Address Balto City Hosp. Date signed 11-1-48

83a

668150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Aiken St.
(c) Hospital or institution: 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE BARNES BUCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Maxwell A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 20, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	9	hr. min.

9. Birthplace Norwich, Conn (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William W. Barnes
13. Birthplace Norwich, Conn

MOTHER
14. Maiden Name Martha Williams
15 Birthplace Norwich, Conn

16 (a) Informant William B. Hall
(b) Address 7108 Chambers Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1930 to Oct 29 1948 and that I last saw h[illegible] alive on Oct 29 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cardio Vascular Dis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J Schnitzer M D
Address 2700 Harford Rd Date signed 10-30-48

68101 BC-F62480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

010 ✓ 68101 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Scott St (If rural give location)
(e) Citizen of foreign country? Yes or No ✓
If yes, name country

3 (a) FULL NAME DIANE PERRERA ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	none	Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1942

8. AGE: Years	Months	Days	If less than one day
5	11	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Orlando Serra
13. Birthplace Conn.

MOTHER
14. Maiden Name Regina Heckinger
15. Birthplace Baltimore Md

16 (a) Informant Betty Serra
(b) Address 2626 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 E Fort Ave

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1948 at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31, 1948 to Oct 31, 1948 and that I last saw HER alive on Oct 31, 1948

Immediate cause of death	Duration
Laryngeal Obstruction	
Due to Pharyngo-Laryngeal Diphtheria	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy Oct 31, 48
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinske M. D.
Address Sinai Hospital Date signed Oct 31, 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. 668152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4353 Reisterstown Road
(c) Hospital or institution: 15 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4353 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Nee Kerpelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan, 12, 1894

8. AGE: Years	Months	Days	If less than one day
54	9	19	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Ice Dealer

FATHER
12. Name Sidney Nelson
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Monen
15. Birthplace Russia

16 (a) Informant Mrs. Dora Nelson
(b) Address 4353 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 1. 1948 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location Hebrew Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1948 to Oct 31, 1948, and that I last saw h alive on Oct 31, 1948.

Immediate cause of death Cerebral Tumor (Glioma) — Duration 6 mos

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Manuel Levin, M.D.
Address 4818 Reisterstown Rd Date signed Oct 31/48

VS 150

66833 53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 66813 53

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4149 Fairview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ESTHER ROSENZWEIG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years: 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business: None

FATHER
12. Name: Abraham Freeman
13. Birthplace: Poland

MOTHER
14. Maiden Name: Diena ?
15. Birthplace: Poland

16 (a) Informant: Mrs Morris Grossfeld
(b) Address: 4149 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 1, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedlae Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 NOV 1 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-31 1948 at 11 42 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948 to 10-31 1948 and that I last saw her alive on 10-31 1948

Immediate cause of death: Generalized Arteriosclerosis; — Duration

Due to: Diabetes mellitus

Due to:

Other Conditions: Amputation right leg

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Henry Nagel M. D.

Address: Levindale Home Date signed 10/31/48

VS 150

X

66814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. 66814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 E. Lake Ave
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Lake Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Hollstein Jory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herbert G. Jory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John C. Hollstein
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Harman
15. Birthplace Maryland

16 (a) Informant Mr. John G. Jory
(b) Address 3305 Staunton Ave., Charleston, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director Edward O. Mitchell & Sons
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) Nov 1 1948 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948 at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to October 27 1948, and that I last saw her alive on October 27 1948.

Immediate cause of death	Duration
Acute pulmonary edema	½ hour
Due to Arteriosclerotic cardiovascular disease	20 yrs
Due to	
Other Conditions Arterial Hypertension (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Road Date signed 10-27-48

VS 180

68155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 668156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104
(c) Hospital or institution:
The Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 47
(e) Length of stay in Baltimore (yrs., mos., ~~days~~) 80 ? [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton Court Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Pennington

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
F	W	

6 (b) Name of husband or wife Noble Pennington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	16	hr. min.

9. Birthplace Towson, Md.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Joseph J Stewart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Baynes
15. Birthplace

16 (a) Informant Mrs. Clifford E. Waller
(b) Address 1707 Highland Drive Silver Spring Md.

17 (a) Burial (b) Date thereof 11/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Chas. O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (NOV 1 1948) (b) [redacted]
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948 at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948 to Oct. 29 1948 and that I last saw her alive on Oct. 29 1948.

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Metastases from old Breast Cancer	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Coroner Travis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Chesley Decker M. D.
Address Woman's Hospital Date signed 10-29-48

VS 180

Physicians: please write the causes of death clearly and legibly. Cause (a) is especially important.

668446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 668456

Registered No. 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 WINDSOR AVE.
(c) Hospital or institution:
WINDSOR REST HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5wks
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town WOODLAWN (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 KERNAN DRIVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M. SHIPLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. * **

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MLE	W HITE	MARRIED

6 (b) Name of husband or wife DORA A. SHIPLEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 14 - 1892

8. AGE: Years	Months	Days	If less than one day
56	5	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Mrs. Ethel Miller

FATHER
12. Name William Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Martin
15. Birthplace Maryland

16 (a) Informant Mrs. Dora A. Shipley
(b) Address 1908 Kernan Drive, Woodlawn

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. KIPPERT & SON
(b) Address 1300 EUTAW PLACE..17

19 (a) NOV 3 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 29, 1948 19 at 10:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1948 to Oct 29 19 48 and that I last saw h 1 alive on Oct 28 19 48

Immediate cause of death: General carcinomatosis (Metastasis) — Duration 3 mos
Due to Carcinoma of pancreas — 6 mo
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation April-48
Major findings of operation: carcinoma of pancreas - secondaries
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Frederick Lentz M. D.
Address Temple Gardens Date signed Oct 31 48

VS 150

66817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 66817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5155

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-15-07

8. AGE: Years: 41 | Months: 3 | Days: 15 | If less than one day: hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Henry Lewis
13. Birthplace NC

MOTHER
14. Maiden Name Sarah Page
15. Birthplace NC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mulberry Branch
Location Burgaw, N.C.

18 (a) Funeral director Charles C. Cooper
(b) Address 512 N. Carrollton Ave

NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1948 to 10-30 1948 and that I last saw h[illegible] alive on 10-30 1948

Immediate cause of death: Respiratory Failure — Duration: 3 min

Due to meningitis

Due to Miliary Tuberculosis

Other Conditions Tbc. Peritonitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Miliary Tuberculosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan Calkins

Address J H Hosp Date signed 10/30/48 (M. D.)

VS 150

68158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 ✓

Registered No. 68158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 N Dennison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Dennison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Lee Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	widowed

6 (b) Name of husband or wife Nate Geo. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1887

8. AGE: Years	Months	Days	If less than one day
61	5	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Stroud
13. Birthplace Md

MOTHER
14. Maiden Name Susan
15. Birthplace Md

16 (a) Informant Charles Johnson (son)
(b) Address 141 N. Dennison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md.

18 (a) Funeral director Harry F. Whitacre
(b) Address 4101 Edmondson Ave

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948, at 11 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948

	Duration
Immediate cause of death acute cardiac failure	1 day
Due to arteriosclerotic cardio-vascular renal disease	1 yr
Due to diabetes mellitus	7.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Krupp M. D.
Address 3038 Edmondson Ave Date signed 10/31/48

VS 150

131a

668159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

668159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~[illegible]~~ St. Joseph's 27-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6706 Everall (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Louis Henry Simokat

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	— —

6 (b) Name of husband or wife Helena Ursula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	21	hr. min.

9. Birthplace East Prussia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Henry Simokat
FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Schaeffer
MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. John J. Brown
(b) Address 6706 Everall ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Taylor ave.

18 (a) Funeral director Harry H. Nitsche
(b) Address 4101 Edmondson ave.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 28, 1948, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948 to Oct. 28, 1948, and that I last saw h im alive on Oct. 28, 1948.

Immediate cause of death	Duration
Acute myocardial insufficiency	
Due to Arterio-sclerotic Heart Disease	
Due to	
Other Conditions Bronchogenic Carcinoma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Ray E. Brown Jr. M.D. (M. D.)
Address 1 E. Lexington St. Date signed 10/28/48

VS 139

93d

G68160 filed 10/29/48 ✓ 68160

80 = 32144

Med Exam Card

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74A Registered No. 68160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Mansel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce L. Benny

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 3 | Months 7 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Benny
13. Birthplace

MOTHER 14. Maiden Name Sarah Whitside
15. Birthplace

16 (a) Informant G. Sherwood Benny
(b) Address 2633 Mansel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 1 48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Harsen, Md

18 (a) Funeral director Harry H. Mitzel
(b) Address 4101 Eldemere Ave

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1948 at 4:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 12 1948 to Oct 29 1948, and that I last saw him alive on Oct 27 1948.

Immediate cause of death: Leukemia, aleukemic — Duration: 5 mos.

Due to

CERTIFICATION APPROVED BY
Thomas J. Mullen, M.D.
Wm L Hepford M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Leukemia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Wollenweber M. D.
Address 101 W Read St Date signed Oct 30 48

VS 150

68431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 N. Fulton Ave
(c) Hospital or institution: 16-03.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur E. Dunkley

3 (b) If veteran, name war

3 (c) Social Security Account No. 090-05-4615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1894

8. AGE: Years	Months	Days	If less than one day
51	1	29	hr. min.

9. Birthplace Kingston Jamaica B.W.I.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name John Dunkley
13. Birthplace B.W.I.

MOTHER
14. Maiden Name Jane Forbes
15. Birthplace B.W.I.

16 (a) Informant Lillian Maria Allegre
(b) Address 1729 Amsterdam Ave N.Y.C.

17 (a) B. (Burial, cremation, or removal) **(b) Date thereof** 11-2-48 (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Catonsville

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 NOV 1 1948 (Date rec'd by registrar) **(b)** Entombed Mausoleum

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-10 1948, to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death	Duration
Chronic Endocrine Dulces	
Due to Pulmonary Embolism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 11/1/48

68162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓ (C) G68162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Stricker
(c) Hospital or institution: 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-2637

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Grace M. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1877

8. AGE: Years	Months	Days	If less than one day
71	-	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laboratory Man
11. Industry or business Bosman Gunn Ale Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Grace M. Cook
(b) Address 310 N. Stricker St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel M. Sullivan Jr.
(b) Address 10 N. Arlington Ave.

19 NOV 1 1948 (Date rec'd by registrar) (b) Interment Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948, at 6 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1948 to 10/29 1948, and that I last saw h-- alive on 10/14 1948.

Immediate cause of death Myocardial failure

Due to Arterio Sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.
6 mos.
3 dys.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Hart M. D.
Address 601 N. Carrollton Date signed 10/30/48

V S 150

X

G68163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (2403)
(b) Street address 2408 Maryland Ave
(c) Hospital or institution: none 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Linden Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Stanley Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1880

8. AGE: Years 68 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Amos J. Davis
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mamie High
15. Birthplace ?

16 (a) Informant Mr. Elmer C. Smith
(b) Address 2 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Greenmount
Location Greenmount Ave. at Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore

NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948 at 8:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ~~sudden~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 10-31-48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 668164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Hanover St
(c) Hospital or institution: — 43 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) About 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Annie B. Amelung

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Herman J. Amelung
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 4, 1867

8. AGE: Years 81 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business —

FATHER
12. Name ? Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name ? ? ?
15. Birthplace Germany

16 (a) Informant: Mrs. Mary E. Woolford
(b) Address 226 Hanover St, Balto. Md. (Daughter)

17 (a) Burial — (b) Date thereof Tues, Mar 2, 1948
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St.

NOV 1 1948 (b) Washington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. Oct 30 1948 at 9:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/30 1948 and that I last saw her alive on 10/30, 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 8 days

Due to —

Due to —

Other Conditions: Hypertension
Cardio Vascular disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Harry Deitel M. D.
Address 1226 Hanover St Date signed 11/1/48

VS 150

83a

668165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

X ✓ 668165 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. 15 Bishop Lane (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Catherine Buschmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July - 1863

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Jecke (dec.)

13. Birthplace Md.

MOTHER 14. Maiden Name Anna (dec.)

15. Birthplace Md.

16 (a) Informant John Buschmann

(b) Address 15 Bishop Lane Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1948 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Frederick Ave.

18 (a) Funeral director Edward J. Murphy

(b) Address Catonsville, Md.

19 (a) NOV 1 1948 (Date received by registrar) (b) Huntington-Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948 to 10-29 1948 and that I last saw h[illegible] alive on 10-29 1948

Immediate cause of death: Acute Pancreatitis

Due to: Chemical peritonitis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pancreatitis Peritonitis Fatty Liver

Duration: 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John J. Tansey M. D.

Address St Agnes Hosp Date signed 10/29/48

VS 130

68166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68166
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Essex St.
(c) Hospital or institution: 1-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2201 Essex St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Lenz.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine Lenz
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) July 23. 1891

8. AGE: Years	Months	Days	If less than one day
63.	3.	7.	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Carpenter P.R. Railroad
11. Industry or business

FATHER
12. Name Charles P. Lenz
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Catherine Heller
15. Birthplace Germany

16 (a) Informant Josephine Lenz
(b) Address 2204 Essex St.

17 (a) Burial. (b) Date thereof 11/1/1948.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern ave.

18 (a) Funeral director Kendall J. Piel
(b) Address 312 S. Highland ave

19 (a) NOV 1 1948 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/48 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/48 to 10/28/48
and that I last saw h[illegible] alive on 10/31/48

Immediate cause of death Coronary Thrombosis — Duration 2 wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Dr Father F. Hunt M.D.
Address 116 S. East ave Date signed

Michael F. Kinkowski 10/30/48

68107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-4a

Registered No. 68107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp. S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Eutaw
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, ~~married~~, ~~widowed~~, or divorced.

6 (b) Name of husband or wife Margarite Crosby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 31, 1896

8. AGE: Years 52 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Warren Crosby
13. Birthplace Maryland

MOTHER
14. Maiden Name Nelly Smith
15. Birthplace Maryland

16 (a) Informant Partner or admin
(b) Address

17 (a) Burial (b) Date thereof 11-2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St

19 (a) NOV 1 1948 (b) Huntington Williams, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 31 1948, at 5:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948, to 10/31 1948, and that I last saw him alive on 10/31/ 1948

Immediate cause of death	Duration
Cerebral embolism - air probably	
Due to Emphysematous bleb ruptured into bronchiectasis in lung	
Due to Bronchiectasis - left	
Other Conditions Chronic alcoholism c early cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Massive air embolism of heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Henry V. Chase M.D.
Address Mercy Hospital Date signed 10/31/48

100 by

VS 150

8108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 469

Registered No. 66838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs. mos.~~ or days) 35
(e) Length of stay in Baltimore (~~yrs. mos. or~~ days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rocks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Daniel JONES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-21-06

8. AGE: Years	Months	Days	If less than one day
42	6	10	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Carpenters Helper
11. Industry or business

FATHER
12. Name Robt Albert Jones
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Florence Curry
15. Birthplace Harford Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4-48 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge Cemetery Co.
Location Belair Md.
18 (a) Funeral director Leupert & Marbine
(b) Address Belair Md.
19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 1948 at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Sept 1948 to 31 Oct 1948 and that I last saw him alive on 31 Oct 1948

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Carcinoma Pancreas & metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: Abdominal tumor, inoperable.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no) (Specify)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hospital Date signed 10-31-48

VS 150

8169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 ✓ G68169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 N. Patterson Pk. Ave
(c) Hospital or institution:

§ C4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME George C. Butera

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No. 220-07-0374

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Rose M. Butera
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr) July 24 1921

8. AGE: Years	Months	Days	If less than one day: hr.	min.
27	3	5		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business U.S. Air

FATHER
12. Name Frank Butera
13. Birthplace Italy

MOTHER
14. Maiden Name Angela Marino
15. Birthplace Italy

16 (a) Informant Rose M. Butera
(b) Address 1432 N. Patterson Pk. Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11 - 2 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director John C. Milly Sons
(b) Address 2435 E. Oliver St

1948 NOV 1 1948 (Date rec'd by Registrar) (b) Hunting for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 29 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Oct 1948.
and that I last saw him alive on Oct. 25 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to polycythemia vera
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Edward Moran M. D.
Address 101 W. Read St Date signed 10-29-48

VS 150

668170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 668170

Please write the words "None" where the items are not applicable, and do not leave any blank unless directed to do so. Write plainly and in ink. Use only standard abbreviations. Please write the words or death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 S. Ann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 412 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Kowalczyk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank Kowalczyk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business At home

FATHER
12. Name Casimir Maluszyk
13. Birthplace Poland

MOTHER
14. Maiden Name A. Gajewski
15. Birthplace Poland

16 (a) Informant Kasimira Kowalczyk
(b) Address 412 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

NOV 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1945 to Oct. 30 1948 and that I last saw h Cr alive on Oct. 30 1948

Immediate cause of death: Coronary Occlusion — Duration 10/30/48

Due to: Hypertensive Arteriosclerotic — 12/27/45

Due to: Cardio-Vascular Dis.

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Krenger M. D.
Address 209 N. Charles St Date signed 11/1/48

VS 150

G68171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G68171 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Szulkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Theodore Szulkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Antek
15. Birthplace Poland

16 (a) Informant Bernice Chmielewski
(b) Address 222 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 NOV 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1948 to Oct 28 1948, and that I last saw h alive on Oct 28 1948.

Immediate cause of death	Duration (Interval)
Hypostatic pneumonia	1 day
Due to Acute Myocardial Infarct	2 days
Due to	
Other Conditions Arteriosclerosis	Yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

Please write the cause of death clearly and legibly.

G68172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47C

G68172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S Durham St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A Gable

3 (b) If veteran, name war	3 (c) Social Security Account No.
/	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agnes Gable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1902

8. AGE: Years	Months	Days	If less than one day
46		18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name No Record
	13. Birthplace
MOTHER	14. Maiden Name
	15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 NOV 1 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1947 to Oct 28 1948 and that I last saw h[illegible] alive on Oct 28 1948.

Immediate cause of death Conjestion of Left Ventricle

Due to Metastasis To Right Lung, Left Kidney

Due to Mental, Nervous Symptoms

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation December 1947

Major findings of operation: Carcinoma Inoperable

of autopsy:

Duration One year

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F Faltick M. D.
Address 2 West Read Date signed Oct 28 48
Balto

VS 150

G68173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13a ✓

Registered No. G68173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 W. Franklin St.
(c) Hospital or institution: 17-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Gurley, (Gerley) (Gary)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife Joseph Gary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-82

8. AGE: Years	Months	Days	If less than one day
66	6	9	hr. min.

9. Birthplace Elkton, Maryland (Cecil) (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Armetta Jenkins
15. Birthplace Maryland

16 (a) Informant Louis C. Brown
(b) Address 827 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) NOV 1 1948 (b) Registered by Huntington Hillsdale, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Oct 30 1948 and that I last saw h[illegible] alive on Oct. 30 1948.

Immediate cause of death — Duration

Cardio-Vascular Accident — 7

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Law M. D.
Address 802 Madison Ave. Date signed Nov 1 48

68174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 133 N Registered No. 68174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymon and Dukeland
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Baker St #16
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Carmine

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2735

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elva Carmine
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr) Dec. 6, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	25	hr. min.

9. Birthplace Baltimore. MD.
(Town, county, and state)
10. Usual Occupation Tool maker
11. Industry or business Glenn L. Martin Co

FATHER
12. Name EARL J. CARMINE
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name ELEANORA NEAL
15. Birthplace BALTIMORE MD.

16 (a) Informant MRS. ELVA E. CARMINE
(b) Address 3018 BAKER ST.

17 (a) BURIAL (b) Date thereof 11-3-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN - MD

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (a) NOV 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1948, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/31 1948.
and that I last saw him alive on 10/31 1948.

Immediate cause of death Uremia

Due to Polycystic kidneys

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. B. Hooper M.D.
Address J. W. B. Hooper Hospital Date signed 10/31

VS 193

68175 Blum

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516 Registered No. G68175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3961 Willsby Avenue
(c) Hospital or institution:
9 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3961 Willsby Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Gabriel J. Rhein

3 (b) If veteran, name war [redacted] (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 17, 1870

8. AGE: Years	Months	Days	If less than one day
78	2	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Rhein
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Thierolf
15. Birthplace Germany

16 (a) Informant Mrs. Henry J. Butt
(b) Address 3961 Willsby Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 NOV 1 1948 Huntington Williams, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 28 1948 and that I last saw h/xx alive on Oct 28 1948.

Immediate cause of death Carcinoma of Prostate Gland — Duration 6 mos.
Due to
Due to
Other Conditions Arteriosclerotic Cardio-Vascular Renal Disease — 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Joseph S. Blum
Address 1115 N Calvert St Date signed 10/28/48 (M D)

VS 150

68176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glendale (If outside city or town limits, write RURAL and give town)
(d) Street No. 8312 Beach Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Madeline (Madge) Jester (Gladys Madeline (Madge) Jester)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Oct 1948 at 11:53 A M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George C. Jester
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) March 21, 1903

8. AGE: Years	Months	Days	If less than one day
45	7	9	hr. min.

9. Birthplace New Market, Tennessee (Town, county, and state)
10. Usual Occupation School-teacher
11. Industry or business Baltimore County, Md.

FATHER
12. Name Henry Dario Pollard
13. Birthplace Tennessee

MOTHER
14. Maiden Name Martha Elizabeth Hatcher
15. Birthplace Tennessee

16 (a) Informant George C. Jester
(b) Address 8312 Beach Drive Glendale Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Balto. Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 1003 W. Baltimore St.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by [illegible] Year)

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry), find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage,
Spontaneous
Due to Hypertension and P.V. Disease
Other Conditions Fractured Skull
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Beyer M.D. Medical Examiner.
Date signed 30 Oct 48

NOV 1

G68177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186

Registered No. G68177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Scott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LENA (MANNER) MARTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Theodore C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1876

8. AGE: Years	Months	Days	If less than one day
72	5	18	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: home

FATHER
12. Name: Paul Manner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Annie Wagoner
(b) Address: 1151 W. Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Longwood & Edmondson Avenue

18 (a) Funeral director: JOHN J. COWAN & SON
(b) Address: 1101-03 Hollins Street

19 (a) NOV 1 (Date rec'd by registrar) (b) Huntington Matheson, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of left femur

Due to: Arteriosclerotic cardiovascular disease -

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-48 at ? M.
(b) Where did injury occur? Court House
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No (outside)
(d) Means of injury: Slipped and fell down steps

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 11/1/48

G68178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. Baltimore ST
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County —
(c) City or town Piedmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 52 W. Harrison ST
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Isabella Stanley

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Mr. Forrest Stanley
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Dec. 20, 1877

8. AGE: Years 70 | Months 10 | Days 11 | If less than one day — hr. — min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Jacob Ogden
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah L. Watson
15. Birthplace West Virginia

16 (a) Informant Mrs. M. Griffin
(b) Address Church Home and Hospital

17 (a) personal (b) Date thereof 11/1/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Piedmont West Va.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eleanor St - 31 -

19 (a) NOV 1 1948 (b) Huntington Williams, Mgr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1948, at 11:38 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/31 1948. and that I last saw her alive on 10/26 1948

Immediate cause of death Cardiac failure
Due to Respiratory paralysis
Due to Myasthenia Gravis
Due to Generalized arteriosclerosis
Other Conditions Fecal impaction

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. W. Mintzer
Address Church Home Hosp Date signed 11/1/48

VS 150

97

668179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120a

Registered No. 668179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 12 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3201 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAE MORGAN (COLLINS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1909

8. AGE: Years	Months	Days	If less than one day
38	11	19	hr min.

9. Birthplace Columbia, N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Zion Midgett
13. Birthplace Columbia, N.C.

MOTHER
14. Maiden Name Mary E. Askew
15. Birthplace Columbia, N.C.

16 (a) Informant Mrs. Caddie Nelson (sister)
(b) Address 2434 N. 15th St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-48 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bantes ave

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948 at 4:30A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute gastro enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Kaye M.D. Medical Examiner.
Date signed 10/29/48

68180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 68180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Colvin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Leak HATTIE LEAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1894

8. AGE: Years	Months	Days	If less than one day
53		19	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Jack McEachin
(b) Address 246 Colvin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Gilmor St

19 (a) [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1948, at 2.30 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or in public place? While at work?
(d) Means of injury

23. Signature Emil Rayn M.D. Medical Examiner.
Date signed 10-31-48

VS 151

Liedtke

68181 ✓ 68181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Gwin's Institute

(c) Hospital or institution: Mercy Hosp. 71

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2917 Reuckert Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Lillian Fredtke

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948, at 7:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948 to 10-31 1948, and that I last saw h alive on 10-31 1948.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	W

6 (b) Name of husband or wife Frederick L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1906

8. AGE: Years	Months	Days	If less than one day
41	11	17	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Dr. Frederick Humberg

13. Birthplace N.Y.

MOTHER

14. Maiden Name Lily A. Halberstadt

15. Birthplace England

16 (a) Informant Mr Fred. Humberg

(b) Address 2917 Reuckers Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Co. Md.

18 (a) Funeral director L. J. Ruck

(b) Address 5[illegible] Raiford Rd

19 (a) NOV 1 1948 (b) [illegible] Registrar

(Date rec'd by registrar)

Immediate cause of death Metastatic carcinoma

Due to Lung

Due to a & breast.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Date of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Howard E. Hull M.D.

Address 10-31 Lex. M. Date signed 11-6

VS 153

668182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668182

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 824 S. Clinton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 824 S. Clinton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA ROTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Roth

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) May 15, 1867.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
81	5	16		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business House Work

FATHER 12. Name John Doetzer

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Meyer

15. Birthplace Germany

16 (a) Informant Joseph Roth

(b) Address 824 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48. (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cemetery

Location German Hill Rd.

18 (a) Funeral director Charles S. Zailer.

(b) Address 901 S. Conkling St.

19 (a) NOV 1 1948 (Rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 48 10:30A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 23 1948 to Oct 31 1948 and that I last saw h alive on Oct 31 1948

Immediate cause of death: Cerebral Hemorrhage

Due to: Emboli;

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Duration: Oct 31 48

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Ball M.D.

Address 3426 Ball St Date signed

3426 Ball St

G68183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Winston Ave
(c) Hospital or institution: 27-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Winston Ave
(If rural, give location)
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Elizabeth Tischinger

3 (b) If veteran, name war: X

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife: August Robert Tischinger
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1890

8. AGE: Years	Months	Days	If less than one day
58	1	3	hr. min.

9. Birthplace: Harford Co., Md. (Magnolia)
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas S[illegible]llman
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Frances V. Baldwin
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mr. Roland Tischinger
(b) Address: 421 Winston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Govans Presby. Cem.
Location: Govans, Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 1 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948 to Oct 30 1948 and that I last saw her alive on Oct 30 1948

Immediate cause of death	Duration
Coronary Occlusion	24 hours
Due to Myocarditis	8 mos
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther Leggett M. D.
Address 3812 Gooseneck Date signed Oct 31 48

VS 150

68184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 7 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5225 Reisters Town Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dora C. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife: Nelson E. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1860

8. AGE: Years	Months	Days	If less than one day
88	1	6	hr. min.

9. Birthplace Port Republic, Va.
(Town, county and state)

10. Usual Occupation Housewife Retired

11. Industry or business

FATHER
12. Name Baldwin Harris
13. Birthplace Va. d'ed

MOTHER
14. Maiden Name Elizabeth Lawrence
15. Birthplace Va.

16 (a) Informant Mrs. Kluth, Daughter
(b) Address Groveland ave 4105

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville 8, Md.

18 (a) Funeral director WM. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

50 P.

20. DATE OF DEATH 10-31 1948 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1948; to 10-31 1948 and that I last saw h-- alive on 10-31 1948

Immediate cause of death acute diffuse peritonitis. — Duration one wk

Due to Incarcerated hernia (inguinal) with gangrene ? perforation.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-22-48

Major findings of operation: Strangulated inguinal hernia, left. Gangrenous ileum & perforation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. W. Sherwin M. D.
Address St Agnes' Hosp Date signed 11-1-48

L. W. Sherwin

VS 150

G68185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G68185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Church Home
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jemima Bridgeford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	none

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8, 1861

8. AGE: Years	Months	Days	If less than one day
87 11111	7 —	22	hr. min.

9. Birthplace ? Scotland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name — Robert Bridgeford
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Valentine
15. Birthplace Scotland

16 (a) Informant Miss Jemima Bridgeford
(b) Address Church Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/1948 at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1948 to 10/30 1948 and that I last saw her alive on 10/30 1948.

Immediate cause of death Cardiac failure — Duration

Due to hypertension, CVD grade IV decompensated

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. W. Mintz M. D.
Address Church Home Date signed 10/31/48

VS 130

G68186 ✓ G68186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 r 6

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5809 Reisterstown Rd
(c) Hospital or institution:
7-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Maria Louisa Reisinger

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, married, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband or wife: Charles F. Reisinger
6 (c) If alive, give age yrs.
7. Birth date of deceased (mo., day, yr.) Sept-9-1861
8. AGE: Years 87 | Months ~~12~~ | Days 21 | If less than one day: hr. min.
9. Birthplace Reisterstown Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Domestic

FATHER
12. Name John W. Knight
13. Birthplace Reisterstown Md

MOTHER
14. Maiden Name Lydia Knight
15. Birthplace Lewisville, Pa

16 (c) Informant Mrs Ella O'Neal
(b) Address 5809 Reisterstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville 8, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Oct 30 1948, and that I last saw her alive on Oct 28 1948.

	Duration
Immediate cause of death Chronic I.	Unknown
1. Mitral Endocarditis	
Due to 2. Arterio-Sclerosis	10 yrs
Due to 3. Senility	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Ensor M. D.
Address 7201 York Rd Date signed 10-20-48

G68187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G68187
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 West Rogers Ave.
(c) Hospital or institution: Home for the Aged of the Meth. Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27-15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE RATHELL COTTINGHAM

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Walter Cottingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 28, 1869

8. AGE: Years	Months	Days	If less than one day
79	8	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Rathell
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Eliza C. Krebs
15 Birthplace Balto., Md.

16 (a) Informant Miss Miriam O. Coates, Supt.
(b) Address Home for the Aged of the Meth. Ch.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to Oct 29 1948 and that I last saw h[illegible] alive on Oct 29 1948.

Immediate cause of death	Duration
(a) Cerebral hemorrhage	6 days
Due to (b) Arterio sclerosis	10 yrs
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 W 38th St Date signed 11-1-48

VS 150

G68188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 2

G68188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 S. Collington
(c) Hospital or institution: 1-05

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Collington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella May OLIVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Benjamin F. Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1880

8. AGE: Years 68 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Charleston, W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert W. Peaco
13. Birthplace

MOTHER
14. Maiden Name Emma Jenkins
15. Birthplace

16 (a) Informant Mrs. Joseph Wilson
(b) Address 1601 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48

(c) Cemetery or crematory Oak Lawn
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & Sons
(b) Address Balto., Md.

19 NOV 1 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/48 19 10:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ravenscroft M.D.
Medical Examiner.
Date signed 10/31/48

68189

Medical Examiners Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68189

GM. 124088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Crane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July -29-1871

8. AGE: Years	Months	Days	If less than one day
77	3	1	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

CERTIFICATION APPROVED BY
Howard J. Madden, M.D.
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) [illegible] 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 - 1948, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 1948 to 10-30- 1948, and that I last saw h in alive on 10-30- 1948

Immediate cause of death	Duration
Uremia	days
Due to Hypertensive Cardio-Vascular disease	?
Due to	
Other Conditions Gradual Sinking	7 days

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence October 24, 1948 at ? M
(c) Where did injury occur? Baltimore, Maryland
S.W. corner Charles & Cross (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place While at work? no
(Specify type of place)
(e) Means of injury Tripped and fell to street

23. Signature Norman F. Lord, M.D. M. D.
Address 1940 Eastern Ave Date signed 11-25-48

VS 159

To Be Approved By Medical Examiner.

68190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. 68190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave and Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 11-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 W Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-9557

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	24	hr. min.

9. Birthplace York, Penna. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William G. Wheeler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Augusta E. Wilhelm
15. Birthplace Baltimore

16 (a) Informant Mrs. Oliver Eckhart
(b) Address 13 Cedar Ave., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) Nov 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948 at 7 30 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Peter B. McFadden M.D. Medical Examiner.
Date signed 10-31-48

G68191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167 Registered No. G68191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Layfayette Street Ave W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie (Weaver) BENNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-2336

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1903

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Florence, S. C.

10. Usual Occupation Chef

11. Industry or business ?

FATHER 12. Name Unknown
13. Birthplace South Carolina

MOTHER 14. Maiden Name Unknown
15. Birthplace South Carolina

16 (a) Informant: Lizzie Watkins
(b) Address 717 Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Halstead & Reed Hill ave.

18 (a) Funeral director
(b) Address

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Lafayette Milliner

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, 9:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of Aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-48 at P. M.
(b) Where did injury occur? Lafayette & Brunt Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature M.D.
Medical Examiner.
Date signed 11-1-48

VS 18

668192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N. Lakewood Ave
(c) Hospital or institution: L-O-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giulia Biscotti

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.: NONE

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband Xxxxx Michele Biscotti

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1878

8. AGE: Years	Months	Days	If less than one day
70	8	3	hr. min.

9. Birthplace Lama di Peligna -Chieti- Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nicola Sebastiani
13. Birthplace Italy

MOTHER
14. Maiden Name Maria ?
15. Birthplace Italy

16 (a) Informant Michele Biscotti (Husband)
(b) Address 205 N. Lakewood Ave

17 (a) Burial (b) Date thereof Nov. 3rd/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 900 S. High St.

19 NOV 1 1948 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948 at 2:35 P M

21. I certify that I took charge of the remains described above, held an Ext & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helbrecht M.D.
Medical Examiner.
Date signed Oct 31, 1948

VS 151

68193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Duncan St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Bornicak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Bornicak

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 2-2-1882

8. AGE: Years	Months	Days	If less than one day
66	8	29	hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER 12. Name John Ptacek

13. Birthplace Austria

MOTHER 14. Maiden Name Not known

15. Birthplace Austria

16 (a) Informant Joseph S. Bornicak

(b) Address 1417 N. Duncan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rood Cemetery

Location Balto Md

18 (a) Funeral director Frank Brock & Son

(b) Address [illegible]

19 NOV 1 1948 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1948 at 1:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 1 1947 to Oct 31 1948 and that I last saw h[illegible] alive on Oct 29 1948.

Immediate cause of death Acute Cardiac Failure — Duration 1 day

Due to

Due to

Other Conditions Cancer of the Uterus — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.

Address 2413 E Monument St Date signed 11/1/48

VS 150

G68194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G68194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 N. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Matula

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Matthew Matula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	28	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name John Matuela
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Frank Matula
(b) Address 513 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Covach & Son
(b) Address 900 S. Ellwood Ave

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 6:10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1947 to Oct 28 1948, and that I last saw h[er] alive on Oct 28 1948.

	Duration
Immediate cause of death Coronary Thrombosis	10/26/48
Due to Chr. Myocarditis	9/1/47
Due to Hypertensive Cardio vascular disease	9/1946
Other Conditions Generalized arterio-sclerosis (Include pregnancy within 3 months of death)	9/1946

Date of operation
Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bauer M. D.
Address 801 N. Eden St Signed 10/29/48

VS 150

68195
AB-124068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48-24209 159

Registered No. 68195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Falcon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26-1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Falcon
15. Birthplace N.C.

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B. C. Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) NOV 1 1948 Huntington Williams, M.D.
(Date received) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27- 1948, at 12.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 1948 to 10-27- 1948, and that I last saw him alive on 10-27- 1948

Immediate cause of death: Prematurity — Duration: 1day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Williams M.D.
Address Date signed Oct 29

8196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C68196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 S. Durham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 S. Durham St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Stackowits

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1, 1910

8. AGE: Years	Months	Days	If less than one day
38	0	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machanist
11. Industry or business

FATHER
12. Name William Stackowitz
13. Birthplace Poland

MOTHER
14. Maiden Name Carrie ?
15. Birthplace Poland

16 (a) Informant Lottie Tiletsky
(b) Address 121 S. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 103 S. Wolfe St. Baltimore 31, Md.

19 NOV 2 1948 (b) Huntingdon Pittsville, Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948, at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 , to Oct 29 1948 and that I last saw him alive on Oct 29 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Sborofsky M.D.
Address 601 N. Monroe St. Date signed 11/1/48

VS 150

This is a copy; please write the causes of death clearly and legibly.

68197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hammen

3 (b) If veteran, name war
3 (c) Social Security Account No. 217-07-2487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice V. Hammen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Hammen
13. Birthplace Unknown

MOTHER
14. Maiden Name ?
15. Birthplace "

16 (a) Informant Alice V. Hammen
(b) Address 20 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) Nov 2 1948 Turlington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30/48 1948 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-26 1948 to Oct 30 1948
and that I last saw h/m alive on Oct 30 1948

Immediate cause of death ARTERIOSCLEROSIS — Duration 3 YRS
due to CVA INT NOOM. — 3 YRS
Due to (Due to, or as a consequence of) —
Due to —
Other Conditions HYPERTENSION — (?)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work;
(Specify type of place)
(e) Means of injury

23. Signature James F. Kavanaugh M.D.
Address 3014 McElderry St Date signed Nov 1 48 M. D.

VS 180

X

G68198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frances H. Voertman

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	NO	FM	White	Widowed

6 (b) Name of husband or wife George A. Voertman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 23, 1866

8. AGE: Years	Months	Days	If less than one day
82	0	8	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation Home
11. Industry or business Home

FATHER
12. Name Micheal Hettinger
13. Birthplace New York

MOTHER
14. Maiden Name Elizabeth Reid
15. Birthplace Kentucky

16 (a) Informant Mary E. Voertman
(b) Address 406 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) NOV 2 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1948 19 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1948 to Oct. 31 1948, and that I last saw h[illegible] alive on 10-30-1948.

Immediate cause of death	Duration
Organic Heart Disease	Unknown
Due to	
Due to	
Other Conditions Influenza	10 da.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 11-1-48

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G68193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

G68199 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-08
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Kennedy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andy Pavlicsak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of husband or wife Julia Ann Pavlicsak 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	0	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Joseph Pavlicsak
13. Birthplace Hungary

MOTHER
14. Maiden Name Ann Asch
15. Birthplace Hungary

16 (a) Informant Julia Ann Pavlicsak
(b) Address 1911 Kennedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore MD
Location Baltimore

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

19 NOV 2 1948 (Date rec'd by Registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Oct 1948, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures of Skull & intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9-8
(a) Date of injury 31 Oct 48 at 12:45 A.M.
(b) Where did injury occur? Kennedy & Pratt Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Auto

23. Signature Emil L. Rudy M.D.
Medical Examiner
Date signed 31 Oct 48

VS 181

668200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. 668200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & Mt. Vernon Place
(c) Hospital or institution: Washington Apts. 1107
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles St. & Mt Vernon Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA R. WINDER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Female	White	Married

6 (b) Name of husband or wife John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 11, 1867

8. AGE: Years	Months	Days	If less than one day
81	0	19	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Ransom
13. Birthplace New York

MOTHER
14. Maiden Name Georgia Anderson
15 Birthplace Maryland

16 (a) Informant John H. Winder
(b) Address Washington Apts, Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 2 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 19 , at 4 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death Myocarditis
Arterio Sclerosis

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Hoadley, M. D.
Address 1403 Park Ave Date signed 11/1/48

VS 190

668201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 St. Paul Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME: CAROLINE PIRRONE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Anthony Pirrone
6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): October 12, 1877

8. AGE: Years: 71 | Months: 0 | Days: 19 | If less than one day: ____ hr. ____ min.

9. Birthplace: Italy (Town, county and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Augustine (?)
13. Birthplace: Italy

MOTHER
14. Maiden Name: Pirrone (?)
15. Birthplace: Italy

16 (a) Informant: Vincent Pirrone (son)
(b) Address: 1929 St. Paul St.

17 (a) Burial, cremation, or removal: Interment (b) Date thereof: 11/4/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore Md.

18 (a) Funeral director: William J. Lee
(b) Address: 1219 E. Fort Ave.

19 (a) Filed [illegible] 1948 (b) Transcribed by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1948 at 9 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 10/31 1948. and that I last saw h[illegible] alive on 10/31 1948.

	Duration
Immediate cause of death: Coronary Occlusion	1 day
Due to: Coronary sclerosis	
Due to:	
Other Conditions: Cardiac failure; Residual of Cerebral Accident; Diabetes Mellitus; Generalized arteriosclerosis (any surgery within 8 months of death)	over

Date of operation:
Major findings of operation:
of autopsy: Adrenal tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. A. Lane
Address: Md. Gen'l. Hosp. Date signed 11/1/48 M. D.

VS. 199

94a

68202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
1649 East 25th Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 East 25th Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LESSIE W. ENTLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Feamale	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept.7,1872

8. AGE: Years	Months	Days	If less than one day
76	1	23	hr. min.

9. Birthplace Shepherdstown, W.Va.
(Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name John P. Entler
13. Birthplace W.Va

MOTHER
14. Maiden Name Amelia Walters
15 Birthplace W.Va.

16 (a) Informant Mrs L. Rust
(b) Address 1649 E. 25th St.

17 (a) Removal (b) Date thereof 11/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elmwood
Location Shepherdstown, W.Va.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 2 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.30 1948, at 6.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Oct 30 1948.
and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerotic Cardiovascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11-3-48

VS 150

68203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 68203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette St.
(c) Hospital or institution:
Bon Secours Hospital 19 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Placidus Rattenberger, O. S. B.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1892

8. AGE: Years 56 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Essenbach, Bavaria (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business Pastor of 14 Holy Martyrs Church

FATHER
12. Name Adam Rattenberger
13. Birthplace Essenbach, Bavaria

MOTHER
14. Maiden Name Johanna Flugel
15. Birthplace Hettenbach

16 (a) Informant Rev. Roland
(b) Address 101 S. Mount St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 2/48. (month, day, year)
(c) Cemetery or crematory St. Vincents
Location Latrobe, Pa.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave. Funeral for Mt. Savior, Pa.

19 (a) NOV 2 1948 (Date rec'd by Registrar) (b)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/48 19 , at 11:50 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? (Write or specify)
(d) Means of injury

23. Signature John R Ward M.D.
Medical Examiner.

Date signed 11/1/48

668204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓ Registered No. 668204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 E. Lafayette Ave.
(c) Hospital or institution:
8 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADAM RENTSCHLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-2277

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beatrice M.

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 18, 1889

8. AGE: Years 59 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Race Track worker

11. Industry or business

FATHER
12. Name: Adam Rentschler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna M. Grossman
15. Birthplace: Germany

16 (a) Informant: Mrs. Adam M. Rentschler
(b) Address: 1905 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 2 1948 (Date rec'd by registrar) (b) Huntington Nelligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Oct 30 1948. and that I last saw him alive on Oct 29 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	2 years
Due to: Coronary Sclerosis	5 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed Oct. 4

VS 159

X

68205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓

Registered No. 68205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 05

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Darley Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: LILLIAN BAERSCHMIDT

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Adam A. Baerschmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1874

8. AGE: Years 73 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: John C. Fink
13. Birthplace: Maryland

MOTHER 14. Maiden Name: Dora Metz
15. Birthplace: Maryland

16 (a) Informant: Adam A. Baerschmidt
(b) Address: 1740 Darley Ave. #13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (Date rec'd by Registrar) NOV 2 1948 (Signature of Registrar) Evelyn Williams, Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 1 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948, to 10/31 1948, and that I last saw h alive on 10/30 1948.

	Duration
Immediate cause of death: Cardio-respiratory Failure	
Due to: Cerebral [redacted]	9 days
Due to: Hypertensive + A.S.H.D.	10 yrs.
Other Conditions: Hypertrophic Arthritis (Include pregnancy within 3 months of death)	

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. A. Starr M.D.
Address: Md. Gen'l Hosp. Date signed 10/31/48

VS 199

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68206

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 169

Registered No. G68206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 1-05

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD NELSON

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 216-10-5043

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Amelia
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 28, 1895

8. AGE: Years	Months	Days	If less than one day
53	5	3	hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation
11. Industry or business Arundel Sand & Gravel

FATHER
12. Name Matti Nelson
13. Birthplace Norway

MOTHER
14. Maiden Name Mary ?
15. Birthplace Norway

16 (a) Informant Mrs. Amelia Nelson
(b) Address 2100 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue and Broadway

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 4:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions Acute dilatation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-48 at ? P. M.
(b) Where did injury occur Foot of Bond Street
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Fell from box car and dragged

23. Signature Earl K. Rose M.D. Medical Examiner
Date signed 10-31-48

VS 191

668207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668207

CM. 123867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Foster Copeland (FOSTER HARVEY COPELAND)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	213-07-6193	M	W	M

6 (b) Name of husband or wife Maude M.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	8	17		

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business Beth. Steel Co. Sp. Pt.

FATHER
12. Name John Copeland
13. Birthplace N.C.

MOTHER
14. Maiden Name Esther Copeland
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 2 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by reg'r)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31- 1948, 5.50P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 19- 1948, to 10- 31- 1948, and that I last saw him alive on 10- 31- 1948

Immediate cause of death Uremia — Duration ? ?
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions Erythema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 7140 Eastern Ave. Date signed 11/3/48

VS 150

68208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Street
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lewis Meekins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 1946

8. AGE: Years 1 | Months 11 | Days ? | If less than one day hr. min.

9. Birthplace Chestertown, Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Lewis Meekins
13. Birthplace Md

MOTHER
14. Maiden Name Lillie Morris
15. Birthplace Md.

16 (a) Informant Father Mother
(b) Address Chestertown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Chestertown
Location Chestertown, Md

18 (a) Funeral director Edgar L. Price
(b) Address Chestertown, Maryland

19 (a) NOV 2 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1948 at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov. 2 1948. and that I last saw him alive on Nov. 2 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Laryngeal obstruction	
Due to Acute laryngo-tracheitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/2/48

Major findings of operation: Laryngeal obstruction

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Pleasanton M. D.
Address University Hospital Date signed 11/2/48

VS 150

668209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 668209

A64666 B. C.-48-1645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Fountain, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Licharowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/7/48

8. AGE: Years	Months	Days	If less than one day
	2 1/2		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Licharowicz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Murphy?
15. Birthplace Baltimore

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 2 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Church
Location Balto. County

18 (a) Funeral director John J. Weber
(b) Address 401 E. Chester Street

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-1- 1948 at 4 15- A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1948 to 11-1- 1948 and that I last saw h[illegible] alive on 11-1- 1948.

Immediate cause of death Pneumonia and Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 11-1-48 at 4 15 M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M. D.
Address Johns Hopkins Hospital Date signed 11-1-48

VS 150

668210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

668210 Registered No.

Please write the entries in black ink clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: 17 c 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Armstead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John H. Armstead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Cooper
15. Birthplace Md.

16 (a) Informant John H. Armstead
(b) Address 737 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 3 1948 (Date rec'd by Registrar) Huntington for Williams Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH NOV. 1, 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948, to 11-1 1948, and that I last saw h alive on Nov 1 1948.

Immediate cause of death Carcinoma Rectum

Due to (Carcinoma)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 561 Dolphin St Date signed 11-7-48

68211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 N Caroy St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Guilford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jr. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1897

8. AGE: Years	Months	Days, if	If less than one day
51	8	20	hr. min.

9. Birthplace (Town, County, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Colman Fields
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Carter
15. Birthplace Va

16 (a) Informant William Field
(b) Address 2007 Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 29 1948, and that I last saw h alive on 19

Immediate cause of death	Duration
(a) Acute Myocarditis	Days
Due to (b) Cancer Rectum	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter J Gomez M. D.
Address 401 N Edmondson Date signed 11/2/48

68212

BALTIMORE CITY HEALTH DEPARTMENT 93 d ✓ Registered No. 68212

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 W. 33rd St.
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 W. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT FRANKLIN DAVIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Helen Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 5, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	26	hr. min.

9. Birthplace Parkton, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Continental Can Co.

FATHER
12. Name Benjamin G. Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Emma R. Miller
15. Birthplace Md.

16 (a) Informant Mrs. Helen Davis
(b) Address 846 W. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Hobbins, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 31, 1948, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to October 1948, and that I last saw h im alive on October 29 1948.

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertensive cardiovascular disease	
Due to Coronary artery insufficiency.	
Other Conditions Aortic insufficiency.	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hale Boggs M.D.
Address 11 E. Chase St. Date signed 11.2.48

VS 150

68213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

68213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A. APPLEBY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	none	female	white	widow

6 (b) Name of husband or wife William Appleby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman C. Frentz
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Dueffelsdorf
15 Birthplace Bremen, Germany

16 (a) Informant Mr. Herman N. Frantz ✓
(b) Address 326 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 1948 (Rec'd by registrar) (b) Tamtington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13, 1948 to Oct. 30, 1948 and that I last saw her alive on Oct. 30, 1948

	Duration
Immediate cause of death Congestive heart failure	
coma & Edmgeduation	10 days
Due to Cerebral Apoplexy	one year
Due to Arterio-sclerosis with hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice F. Skaggs M. D.
Address 3 East Read St. Date signed 11/2/48

VS 150

668214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 W..Lanvale Street
(c) Hospital or institution: 17-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME VICTORIA A. BUTLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 7, 1860

8. AGE: Years	Months	Days	If less than one day
88	-	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Catherine Jacques
15. Birthplace Unknown

16 (a) Informant Mrs. William H. Martin
(b) Address 515 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 NOV 2 1948 (Date rec'd by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 3:15 a/ M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to Oct 31 1948. and that I last saw her alive on Oct. 31 1948.

Immediate cause of death Hypostatic pneumonia — Duration .48 hrs

Due to arteriosclerotic cardio-vascular-renal disease — 10 mon.

Due to

Other Conditions senility — 7.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr
Address 515 Walker Rd Date signed Nov 2 48

VS 150

668215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a ✓ Registered No. 668215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 E.Lanvale Street
(c) Hospital or institution: 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 E.Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schmidt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-24-1486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Matilda C.Knepper
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb.28th.,1874

8. AGE: Years	Months	Days	If less than one day
74	8	3	########## min.

9. Birthplace Baltimore,Maryland
(Town, county, and state)
10. Usual Occupation Retired,Musician
11. Industry or business

FATHER
12. Name Charles Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kopp
15. Birthplace Germany

16 (a) Informant Mrs.Matilda C.Schmidt (Wife)
(b) Address 1619 E.Lanvale Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Avenue,Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 2 1948 (Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st., 1948 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug.4, 1948 to Oct.31,1948. and that I last saw him alive on Oct.30, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage & Hemiplegia	2mo.
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1513 E.North Ave. Date signed 11-1-48

V S 150

668216 Bowler

BALTIMORE CITY HEALTH DEPARTMENT ✓ 9 r d

CERTIFICATE OF DEATH

Registered No. 668216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un. Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2365 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lydia Bowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widowed.

6 (b) Name of husband or wife Robert. Dead. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/3/1902

8. AGE: Years	Months	Days	If less than one day
46	9	28	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joseph Spence
13. Birthplace Md

MOTHER 14. Maiden Name Mary Howard
15. Birthplace Md

16 (a) Informant Mamie Turner
(b) Address 2365 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Longview
Location Longview, Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1300 Pennsylvania Ave

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1948, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1948 to Nov 1 1948, and that I last saw her alive on Oct. 31 1948

Immediate cause of death	Duration
Cardiac arrest.	
Due to Chronic mural disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Bonsano M.D.
Address Un. Hosp. Date signed 11/5/48

VS 150

68217

GM. 123941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0138 Registered No. 68217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4-62
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 659 Vine ST.
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Dates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 [illegible]

8. AGE: Years	Months	Days	If less than one day
32	✓	16	hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Dates
13. Birthplace VA.

MOTHER
14. Maiden Name Martha?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Freedman St

19 (a) [illegible] 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10- 30 - 1948 at 6.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 21 -19 48 to 10-30 - 1948. and that I last saw him alive on 10-30 - 48

Immediate cause of death Respiratory failure — Duration

Due to Tuberculous meningitis — 2 yrs.

Due to Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton M. D.
Address Baltimore City Hospitals Date signed 11/1/48

VS 150

68218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. 68218

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3619 White Ave.

(c) Hospital or institution:

77 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3619 White Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Andrew Weng or Wengrynowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Weng

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Not Know

8. AGE: Years: About 60 | Months | Days | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER

12. Name ?, Weng

13. Birthplace Austria

MOTHER

14. Maiden Name Not Know

15. Birthplace Austria

16 (a) Informant: Mrs. Bessie Weng

(b) Address: 3619 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3-48 (month) (day) (year)

(c) Cemetery or crematory: Holy Trinity Russian

Location: Eldridge Blvd

18 (a) Funeral director: John J. Grebiancke

(b) Address: 1423 S. Paca St

19 NOV 2 1948 Washington Publishing Co. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Oct 30 1948.

and that I last saw him alive on Oct 24 1948.

Immediate cause of death: Congestive heart failure — Duration: 2 mo.

Due to: Arteriosclerotic Heart disease — Duration: many yr.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Mot R. English M. D.

Address: 5113 Belair Rd Date signed 11-1-48

VS 150

8219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. B-44219 (68-19)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 S. Collins Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. Collins Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Leo Quinn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Annie Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	1	20		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Quinn
13. Birthplace Md.

MOTHER
14. Maiden Name Johnna Hankamp
15. Birthplace Md.

16 (a) Informant Mrs. Annie Quinn
(b) Address 503 S. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George D. Harley
(b) Address Franklin Sq. & Fayette St.

19 (a) NOV 3 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948 to Nov. 1 1948, and that I last saw h alive on Oct. 26 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	11 days
Due to arterio Sclerosis	
Due to a Hypertension	5 yr.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature W. Stanson M.D.
Address 1711 Selma Ave. Date signed 11/1/48

VS 150

8220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 68220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:
Home of Our Lady of
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Louise Dwyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 23 1864

8. AGE: Years	Months	Days	If less than one day
84	6	8	hr. min

9. Birthplace Chestertown, Kent Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John W Dwyer
13. Birthplace Chestertown Md

MOTHER
14. Maiden Name Rose Hyder
15. Birthplace Bristol, England

16 (a) Informant Albert V Dwyer
(b) Address 509 E 22nd St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE. & 22nd ST.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/48 19 at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 9 1948 and that I last saw her alive on Oct 9 1948.

Immediate cause of death
Cerebral Hem. 6 yr
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 4 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 753 W. Lafayette Date signed 11-1-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1948 Registered No. 168221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway and Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 40 days
(e) Length of stay in Baltimore (yrs., mos., or days): 40 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Caroline
(c) City or town: Mount Airy (If outside city or town limits, write RURAL and give town)
(d) Street No.: Route 2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: —

3 (a) FULL NAME: Mrs. Myrle Logue

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife: Mr. Milford Logue
6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 2-28-11

8. AGE: Years	Months	Days	If less than one day
37	8	21	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Henry Ogg
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Eunice Fleter
15. Birthplace: Maryland

16 (a) Informant: Lawrence Betty Webster
(b) Address: Church Home & Hosp. Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 5 1948 (month) (day) (year)
(c) Cemetery or crematory: Deer Park Cem
Location: Near Westminster, Md.

18 (a) Funeral director: John R. Byers
(b) Address: Westminster, Md.

NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-2 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1948 to 11-2 1948, and that I last saw h er alive on 11-2 1948.

Immediate cause of death: Cardiac failure — Duration

Due to: Inanition

Due to:

Other Conditions: cirrhosis of liver, splenomegaly, ascites
(Include pregnancy within 3 months of death)

Date of operation: 9-29-48 and 10-19-48

Major findings of operation: Ascites, splenomegaly, cirrhosis of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Richard M. Garrett M. D.
Address: Church Home + Hosp Date signed: 2 Nov 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 1668222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Sixth Street
(c) Hospital or institution: 75-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Sixth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Hildebrandt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1855

8. AGE: Years	Months	Days	If less than one day
93	8	6	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hildebrandt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wensel
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Maryland

18 (a) Funeral director James L. Williams
(b) Address 130 Fort Avenue

19 (a) Nov 3 1948 (Date rec'd by registrar) (b) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 6 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 31 1948
and that I last saw him alive on Oct 27 1948.

Immediate cause of death	Duration
(a) Obstruction of Bowel	6a
Due to Hypertension Cardio.	
Due to Arteriosclerosis	
Other Conditions 82d Age.	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Washington Williams M. D.
Address 816 Asterisk Date signed Nov 2 48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓

Registered No. G68223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4904 Elmer Ave.
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Elmer Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edythe A. McCann - ALSO KNOWN AS - Edith H. McCann

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-2310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Joseph H. McCann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	30	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Demonstrator
11. Industry or business General Flour Mills

FATHER
12. Name William Amos
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Fillinger
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Raymond J. McCann
(b) Address 4904 Elmer Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Ceme.
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1948 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8/48 19.. to 10/30/48, and that I last saw her alive on 10/30 1948.

	Duration
Immediate cause of death Bronchopneumonia	3 days
terminal	
Due to Carcinoma-Lung	1 yr.
Due to Metastasis from breast (rt)	2½ yrs
Other Conditions Metastasis to liver and pancreas	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randolph H. Berkley, M.D. M. D.
Address 5010 Denmore Ave. Date signed 11-1-48

V S 150

X

8-24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 V Registered No. 968-24

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road.
(c) Hospital or institution: Colonial Nursing Home. 2506
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6109 Fair Oaks Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Louisa Heinlein,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 4, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Heinlein,
13. Birthplace Germany,

MOTHER
14. Maiden Name Margaret Gissell,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret Cavey,
(b) Address 1908 W. Fairmount Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948, to 1 Nov 1948, and that I last saw h[illegible] alive on 1 Nov 1948.

Immediate cause of death	Duration
Chronic Congestive Heart Failure	
Due to Hypertensive C.V. Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emil Reyer M. D.
Address 172 Washington Pl Date signed 2 Nov 48

V S 150

93d

68225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G68225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Ridgewood Ave.,
(c) Hospital or institution: 15 / 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Ridgewood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew Henry Fallon,

3 (b) If veteran, name war none

3 (c) Social Security Account No. 213-05-2507

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret Fallon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1877

8. AGE: Years 71 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Menomonee, Wisconsin.
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Meat Packing

FATHER
12. Name Patrick Fallon,
13. Birthplace Ireland.

MOTHER
14. Maiden Name Sabina Coughlin,
15. Birthplace Ireland.

16 (a) Informant Mrs. Margaret Fallon,
(b) Address 3919 Ridgewood Ave.

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Milwaukee, Wisconsin.

18 (a) Funeral director B. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) NOV 3 1948 (Date rec'd by registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948 19 at 11.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to 11/1/1948 and that I last saw him alive on 19 48

Immediate cause of death Coronary Thrombosis.

Due to Hypertension;

Due to Pneumonia

Other Conditions Aortic Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Horton C. Thach M. D.
Address 2151 Wilkins Ave. Date signed

V S 150

68-26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

grd ✓

Registered No. G68-26

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 E. Federal Street
(c) Hospital or institution: 9-09
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 E. Federal Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE M. STROTT

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Strott

6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): July 3, 1871

8. AGE: Years 77 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob C. Pensel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Buschmann
15. Birthplace: Germany

16 (a) Informant: Mr. Charles Strott
(b) Address: 1433 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 3 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 31 1948, at 2.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Oct 31 1948.
and that I last saw h alive on Oct 31 1948.

	Duration
Immediate cause of death: Chronic endocarditis	?
Due to arteriosclerosis	7 yr
Due to High blood pressure	7 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Strott MD
Address 915 S Broadway Date signed 11/1/48

VS 139

X

G68227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

Registered No. G68227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Adler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Fanyie

15. Birthplace Russia

16 (a) Informant Morris Adler

(b) Address 3400 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 200 Eutaw Place

NOV 3 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/ 1948, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/ 1948 to 11/3/ 1948, and that I last saw her alive on 11/2/ 1948.

Immediate cause of death Carcinomatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CA

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B Harris M D

Address Sinai Hosp — Date signed 11/3/48

VS 150

68228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G68228
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy 7-0-r
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Milton ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Mc Ginnis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife George Mc Ginnis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5, 1882

8. AGE: Years	Months	Days	If less than one day
66	7	26	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Meiser
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Kramer
15. Birthplace Baltimore Md.

16 (a) Informant George E. Mc Ginnis
(b) Address 715 N. Milton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2102 Orleans St.

19 (a) NOV. 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/48 19 , at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948 to 10/31 1948.
and that I last saw h[illegible] alive on 10/31 1948.

Immediate cause of death	Duration
Cardio respiratory failure	8 days
Due to Hypertensive Cardio vascular disease	indefinite
Due to Diabetes mellitus	indefinite
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Brennan Jr. M.D.
Address Mercy Hospital Date signed 11-1-48

VE 139

68529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. 68529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 2601
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5903 Kavon Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Conrad Workinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-2429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 27, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Workinger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Schenkel
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace Spenner
(b) Address 5903 Kavon Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 NOV 3 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/ 1948 to 11/1/ 1948
and that I last saw h im alive on 11/1/ 1948

Immediate cause of death	Duration
Acute Cardiac tamponade	
Due to Rupture of left ventricle through a myocardial infarct	
Due to Coronary Thrombosis	5 days
Other Conditions Sigmoid diverticula	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac tamponade

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no; place)
(e) Means of injury

23. Signature J. Joseph Kuzia M.D.
Address 1400 N Caroline St Date signed 11-1-48

VS 159

68230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490 Registered No. 68230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 McCullough St.
(c) Hospital or institution: 12-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 McCullough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza Pierson Ross.

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Vincent Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1910

8. AGE: Years 38 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Howard Co Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Wm Pierson
13. Birthplace Md

MOTHER 14. Maiden Name Ida Henson
15. Birthplace Md.

16 (a) Informant Vincent Ross
(b) Address 2304 McCullough St Balto 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1949 (month) (day) (year)
(c) Cemetery or crematory Locust Chapel
Location Catonsville Md.

18 (a) Funeral director J.C. Higinbotham
(b) Address Ellicott City Md

NOV 3 1949 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1949, at 6 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1948 to Nov 1, 1949 and that I last saw h[illegible] alive on Nov 1, 1949.

Immediate cause of death
(a) Carcinoma of ovary 8 — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Jutkowitz M. D.
Address 2331 Eutaw Pl Date signed Nov 1, 1949

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ G68231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL A. THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	11	14	hr. min.

9. Birthplace Balto. 1, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Balto. 1, Md.

MOTHER
14. Maiden Name Annie
15. Birthplace Balto. Md.

16 (a) Informant Mary Crawley
(b) Address 1312 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantly Ave.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 4:20A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10-29-48

Post mort Room

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. 1668

Medical Examiners Case

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 E. MADISON, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Harrod

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife / 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Harrod
13. Birthplace ?

MOTHER
14. Maiden Name Jinnie ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 3, 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md
18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley ave
19 NOV 3 1948 Huntington Millington Md
(Date rec'd by registrar)

VS 150 To be approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Arteriosclerotic Heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation Robt. B. McFadden, M. D.

per

of autopsy CHIEF MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N P Johns
Address Johns Hopkins Hosp Date signed 11/3/48 M. D.

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES-124164 | 186a | Registered No. 1683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 1103
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 S. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Culler

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 89 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo.

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 NOV 3 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

TO BE APPROVED BY MEDICAL EXAMINER.

MEDICAL CERTIFICATION A

20. DATE OF DEATH 11-1 1948, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948 to 11-1 1948, and that I last saw her alive on 11-1 1948

Immediate cause of death undetermined (?) | Duration

Due to ot. fell on 10/29/48 and sustained a Contusion

Due to

Other Conditions Senility. A.J.C.V.D.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of autopsy: CERTIFICATION APPROVED BY CHIEF OF BUR. OF MEDICAL EXAMINERS M.D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide (Underlined)
(b) Date of occurrence 10/29/48 at 5 PM
(c) Where did injury occur? Baltimore Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury fell down stairs (inside)

23. Signature [illegible] M.D.
Address Balto. City Hosp. Date signed 11/2/48

Please write clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Kolabird Camp (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Swallow Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-91

8. AGE: Years 57 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation W. P. A.

11. Industry or business

FATHER
12. Name Fred Jones
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Sarah Foster
15. Birthplace So. Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelly
(b) Address 1303 Pennsylvania Ave

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 8 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/9 1948 to 11/2 1948, and that I last saw him alive on 11/2 1948.

Immediate cause of death: Cachexia — Duration

Due to Carcinometosis

Due to Carcinome of transverse Colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/11/48

Major findings of operation: Carcinoma of colon and carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Hefler, Jr. M. D.
Address Johns Hopkins Hosp (Date signed) 11/4/48

VS 199

668235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668 [illegible] 978

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 Smithson St
(c) Hospital or institution: 16 or

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Smithson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Thomas Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. 223-20-1586

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced
Male	colored	

6 (b) Name of husband or wife Celina Lee
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 14 1879

8. AGE: Years	Months	Days	If less than one day
69	8	18	hr. ... min.

9. Birthplace Northumberland Co. Va (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business —

FATHER
12. Name James Lee
13. Birthplace Va

MOTHER
14. Maiden Name Emily Swinney
15. Birthplace Va

16 (a) Informant Linda D. Bass
(b) Address 1322 Smithson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (mo.) (day) (year)
(c) Cemetery or crematory Lillian
Location Lillian, Va

18 (a) Funeral director Geo. S. Nelson
(b) Address 1303 Pressman St

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-1948, at 2:PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-18-1948 to 11-2-1948, and that I last saw him alive on 11-2-1948

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: Hypertension & arterio Sclerosis — Duration: unknown
Due to — Duration:
Other Conditions: Diabetes mellitus — Duration: unknown
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 11-2-48

83a

68236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164C

Registered No. 68236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Roland Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHANIEL BARZALLAI HODSKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Elizabeth Hodskin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1918

8. AGE: Years	Months	Days	If less than one day
30	10	29	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation U. S. Postal Employee
11. Industry or business

FATHER
12. Name Nathaniel B. Hodskin
13. Birthplace Caton, N. Y.

MOTHER
14. Maiden Name Anna M. Walker
15. Birthplace Catonsville, Maryland

16 (a) Informant Mrs. Mary E. Hodskin (wife)
(b) Address 1006 Roland Hgts. Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 12:45 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/1/48 at approx. 12:05 A.M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Medical Examiner. M.D.
Date signed 11/1/48

VS 151

68237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 68237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution: Home for the Aged of the Meth. Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADA BLANCHE HAMILTON

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Sherwood Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1877

8. AGE: Years 71 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Friendship, A. A. Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Vinton Leitch
13. Birthplace Friendship, A. A. Co., Md.

MOTHER
14. Maiden Name Ella D. Howard
15. Birthplace Friendship, A. A. Co., Md.

16 (a) Informant Home for the Aged of the Meth. Ch.
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Nov 1 1948 and that I last saw h er alive on Nov 1 1948.

Immediate cause of death Myocardial Insufficiency — Duration 10 days
Due to Arteriosclerosis — 2yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur G Raines M. D.
Address 800 W 33rd St Date signed 11-2-48

VS 159

68238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 468 Registered No. 468

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Riva Alto Drive
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Fingles

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male | Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Susanna C. Fingles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 6-7-66

8. AGE: Years: 82 | Months: 4 | Days: 24 | If less than one day: hr. : min.

9. Birthplace: N. Y. (Buffalo) (Town, county, and state)

10. Usual Occupation: Contractor retired

11. Industry or business

MOTHER | FATHER

12. Name: Thomas Fingles

13. Birthplace: Scotland

14. Maiden Name: Mary ?

15. Birthplace: Ireland

16 (a) Informant

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)

(c) Cemetery or crematory: Cathedral Cem.

Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948, to 11-1 1948, and that I last saw him alive on 11-1 1948.

	Duration
immediate cause of death (1) Probable cerebral metastases, due to (1)	
Due to (2) Carcinoma of prostate with (2) Diabetes mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Norman E Shaw M. D.

Address: Johns Hopkins Hospital Date signed 11-2-48

VS 150

68239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63 L

Registered No. 668239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4515 Garrison Blvd.
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6409 Kriel Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER M. PLOWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife: Sarah Louise Plowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18 1872

8. AGE: Years 75 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace: Unknown (Town, county and state)

10. Usual Occupation: accountant

11. Industry or business: genral book-keeping

FATHER
12. Name: Joseph Plowman
13. Birthplace: Unknown

MOTHER
14. Maiden Name: ? Hess
15. Birthplace: Harford Co Maryland

16 (a) Informant: Walter M. Plowman
(b) Address: deceased.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 19 48, at 6.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Nov 2 1948 and that I last saw him alive on Nov 1 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	5 days
Due to Generalized Arteriosclerosis	?
Due to Senility	
Other Conditions Senile Dementia	3 mos.

(Include pregnancy within 3 months of death)

Date of operation none.
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua Hanna Scott M.D. M. D.
Address 6419 Windsor Mill Road Baltimore 7 Md. Date signed Nov 2 1948

VS 150

68240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered Number 16880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Dallas Court
(c) Hospital or institution: 301
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Fulkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1901

8. AGE:

Years	Months	Days	If less than one day
46	10	15	hr. min.

9. Birthplace Washington, D. C.
(City, county, and state)

10. Usual Occupation Housewife

11. Industry or business ---

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mack Fulkerson
(b) Address 208 S. Dallas Court

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem'l Park
Location Balto. Co. Md.

18 (a) Funeral director B. M. Walters
(b) Address Baltimore, Md.

NOV 3 1948 (Date rec'd by Registrar) NOV 3 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov. 1948 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. A. Kammerer, M.D.
Medical Examiner.
Date signed 2 Nov. 48

VS 151

68241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered Number 16658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S. Parrish St
(c) Hospital or institution: 19 C3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PRUSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife FELIKS PRUSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1- 1891

8. AGE: Years 57 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name PAUL JANICKI
13. Birthplace POLAND

MOTHER 14. Maiden Name BERNICE WAROSKI
15. Birthplace POLAND

16 (a) Informant FELIKS PRUSKI
(b) Address 427 S. PARRISH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 5-1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location Balto Md

18 (a) Funeral director Hoff & Co B.M. Walters
(b) Address PRATT & STRICKER STS

19 (a) Huntington Hilliouse, M.D. (Date rec'd by registrar) Registrar

NOV 3 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 2 1948 at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1948 to Nov 1, 1948 and that I last saw her alive on Nov 1, 1948

	Duration
Immediate cause of death Coronary Infarct	2 days
Due to Coronary Thrombosis	2 days
Due to Hypertensive Cardiovascular Disease	Several yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St Date signed Nov. 2, 48

VS 150

NOV 3 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461 Registered No. 6GRD 42

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 45
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Millrace Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Alberta Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-85

8. AGE: Years	Months	Days	If less than one day
63	1	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McLean Martin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Anne Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hazel Lohr
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Paul C. Schumacher Jr.
(b) Address 3655 Chestnut Ave.

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 November 1948, at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17, 1948 to 11-1 1948 and that I last saw her alive on 10-31, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Carcinoma Gall Bladder	
Due to	
Other Conditions Metastases to liver, colon, mesentery. (Include pregnancy within 3 months of death)	
Date of operation 9-21-48	
Major findings of operation: Widespread tumor Growth.	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury James McC. Finney

23. Signature
Address Union Memorial Hospital Date signed 11-1-48 M. D.

VS 153

68243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 124a

Registered No. C68243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore, 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7804 Harford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Clarke Kilchenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife Adelaide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/70

8. AGE: Years	Months	Days	If less than one day
78	0	28	hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Adam Kilchenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M.
15. Birthplace Germany

16 (a) Informant James Kilchenstein
(b) Address 7804 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Fidelity Luck
(b) Address 5305 Harford Rd.

19 (a) NOV 3 1948 (Date rec'd by Registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31/48 19..... to 11/2 1948 and that I last saw him alive on 11/2 1948

Immediate cause of death: Bronchopneumonia — Duration 1 day
Due to: Cirrhosis of Liver (Laennec's type)
Due to: Peptic Ulcer
Other Conditions: Generalized Arteriosclerosis
Operation: Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature Ray E Brown Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/2/48

VS 150

068244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 ✓ Registered No. 11

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 Lake Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Lake Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. LOVELESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Benjamin O.
6 (c) If alive, give age years.

7. Birth date of deceased (mo., day, yr) Feb. 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	8	18	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Frey
13. Birthplace ?

MOTHER
14. Maiden Name Hannah ?
15. Birthplace ?

16 (a) Informant Mrs. Hilda Plowman
(b) Address 2828 Lake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 6305 Harford Road

19 NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon, 3 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948. to Nov 3, 1948, and that I last saw h[illegible] alive on Mon, 3 1948.

Immediate cause of death — **Duration**

Pulmonary Edema — 1 hour
Due to Cardio - vascular hypertensive Disease — 12 years
Due to Arteriosclerosis — 10 years

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard J. Daiuch M.D.
Address 1 N. Averlea Ave Date signed 11 3 48

68845 Gordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Rosalie Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Rosalie Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Teresa M. Heusler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife John H. Heusler, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min
45	1	19		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad C. Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Leoffler
15. Birthplace Germany

16 (a) Informant Mr. John Heusler
(b) Address 3111 Rosalie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1948 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to Nov 1 1948.
and that I last saw her alive on Oct 31 1948.

Immediate cause of death: Coronary Occlusion — Duration: 4 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury None

23. Signature [illegible] Gordy M.D.
Address 5306 Harford Rd Date signed 11-1-4

38246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18 a

Registered No. 68246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1358 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Naomi Alexander

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-08

8. AGE: Years	Months	Days	If less than one day
40	9	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Orphens Alexander
13. Birthplace Texas

MOTHER
14. Maiden Name Elizabeth Marshall
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cmty
Location Brooklyn Md Baltimore Md

18 (a) Funeral director Gudge P.A. Gibson Sr
(b) Address 1735 Druid Hill Ave

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948, at 3 38 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-31 1948, to 11-1 1948, and that I last saw her alive on 11-1 1948

Immediate cause of death Uremia

Due to Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Ward M. D.
Address Johns Hopkins Hosp. Date signed Nov 1

VS 153

G68247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

135a

G68247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Maryland
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Hayward Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin M Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-6848

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ina Easter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/28/1911

8. AGE: Years	Months	Days	If less than one day
37	7	5	hr min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation unknown
11. Industry or business unknown

FATHER
12. Name Adam Edwin Kraft
13. Birthplace unknown

MOTHER
14. Maiden Name Anna May Martin
15. Birthplace Washington

16 (a) Informant Mrs. W. Ryan
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Nov 5 (day) (year) 48
(c) Cemetery or crematory Easter's
Location Westminster, Md

18 (a) Funeral director A. S. Harry & Sons
(b) Address Westminster, Md

19 (a) (Registered by registrar) (b) Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1948, at 2 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948, to 11-3 1948, and that I last saw him alive on 11-3 1948

Immediate cause of death: Respiratory failure
Cardiac failure
Due to Acute infectious hepatitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E. Hall M. D.
Address Univ. Hosp. Date signed 11-3-48

Type or write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

668248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division
(c) Hospital or institution: Provident Hospital 17 03
(d) Length of stay in hospital or inst. (yrs., mos., or days) day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W Mulberry (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Laure Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1901

8. AGE: Years 46 | Months 10 | Days | If less than one day: hr. min.

9. Birthplace Blackstock, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Harrison.
13. Birthplace Blackstock, S.C.

MOTHER
14. Maiden Name Besty
15. Birthplace Blackstock S.C.

16 (a) Informant Isaac Harrison
(b) Address 1226 East Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1948 (month) (day) (year)
(c) Cemetery or crematory Kingstree S. C.
Location S. C.

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N Schroeder St.

19 (a) (Name of Registrar) (b) Registrar

Date received 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1948, at 2 30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-24 1948, to 10-30 1948, and that I last saw her alive on 10-30 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hospital Date signed 11-2-48

Form 190 Funeral Director, Williams, Md.

G68249 ✓ G68249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. Saratoga Street
(c) Hospital or institution: 18 01

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Webster Neal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Laura Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1888

8. AGE: Years	Months	Days	If less than one day
60	9	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Webster Neal
13. Birthplace Virginia

MOTHER
14. Maiden Name Laibra ?
15. Birthplace Virginia

16 (a) Informant James H. Matthews
(b) Address 1338 Carroll Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Arlington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30th 1948, at 10:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/11 1948 to 10/31 1948.
and that I last saw h alive on 10/25 1948.

Immediate cause of death: Chronic cardio-Vascular Renal disease — Duration: 9 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 600 N. Arlington Ave. Date signed 10-31-48

VS 150

G68250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G68250
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA CUNNINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31				

9. Birthplace Savannah, Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ben Hawkins
13. Birthplace Ga.

MOTHER
14. Maiden Name Carrie Mechel
15. Birthplace Ga.

16 (a) Informant: C lara Smith
(b) Address 230 Linn West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-1948 (month)

(c) Cemetery or crematory
Location Washington D. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bdantley ave

NOV 3 1948 (Date rec'd by registrar) (b)

Funeral Director, Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nove. 2, 1948 at 6:45AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within ... months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 11. 2/48

X

G68251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G68251
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH POLUMBO

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-12-9022

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary Polumbo
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1884

8. AGE: Years	Months	Days	If less than one day
64	11	28	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Stonemason
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mary Polumbo
(b) Address 1130 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Wendell Dippel
(b) Address 312 S. Highland Ave.

93c 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ A, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intestinal obstruction
Arteriosclerotic cardiovascular disease
~~Due to~~

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-1-48

VS 151

G68252 BALTIMORE CITY HEALTH DEPARTMENT 51 G68352
CERTIFICATE OF DEATH Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 Englewood Road
(c) Hospital or institution: 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Englewood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Carter Brogden
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Inglehart Brogden
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 24, 1871

8. AGE: Years	Months	Days	If less than one day
77	5	9	hr. min.

9. Birthplace Long Green, Balto. County, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James McCulloh Brogden
13. Birthplace Roedown, Anne Arundel County, Md.

MOTHER
14. Maiden Name Eleanor Addison Gittings
15 Birthplace Long Green, Balto County, Md.

16 (a) Informant Lucille J. Brogden
(b) Address Hopkins Apts. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity Churchyard
Location Long Green, Balto County, Md.

18 (a) Funeral director Henry W Jenkins & Sons Co
(b) Address York Rd & Rossiter Ave

(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 6 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 14 1941 to Nov. 2 1948.
and that I last saw h(im) alive on Nov 2 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to Arteriosclerosis
Due to
Other Conditions Carcinoma, prostate
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W Cameron M. D.
Address 1109 St. Paul St Date signed 11-3-48

VS 180

820

668253
ES-123543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668253
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS 26-09
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Spangler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 9, 1877

8. AGE: Years	Months	Days	If less than one day
71	8	21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Adam Reiter
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Dunigan
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof Nov. 5-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Herman Hill Rd.

18 (a) Funeral director John J. Connelly
(b) Address 41 E Eastern Ave. Essex Md.

19 (a) (b)
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948 at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948 to 11-1 1948 and that I last saw her alive on 11-2 1948

Immediate cause of death	Heart failure	
Due to	Arteriosclerotic heart disease & chronic failure	
Due to		
Other Conditions	cirrhosis of liver	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David L. Marine M. D.
Address Balto Cty Hosps Date signed 11-2-48

V 3 vs 193

93d

BALTIMORE CITY HEALTH DEPARTMENT 94a Registered No. 668254

CERTIFICATE OF DEATH

668254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-04
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Webster St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME GEORGE E. NEVAKER

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sophia E.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 12, 1893

8. AGE: Years	Months	Days	If less than one day
55	3	20	..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Enginer
11. Industry or business B. & O. R.R.

FATHER
12. Name Peter Nevaker
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Ditzel
15. Birthplace 1242 Carroll St.

16 (a) Informant Sophia E.
(b) Address 1242 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 4:30 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George E. Merrill M.D. (Medical Examiner.)
Date signed 11/2/48

VS 151

68255

C-48-23542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 Registered No. 68255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St.
(c) Hospital or institution: 21-07 Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1262 Washington Blvd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	w	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 25, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation enfant

11. Industry or business

FATHER
12. Name Orus William Thompson
13. Birthplace Clay Co., Ky.

MOTHER
14. Maiden Name Dorothy Mae House
15. Birthplace Corbette, Ky

16 (a) Informant Dorothy Thompson (mother)
(b) Address 1262 Washington Blvd. Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Lexington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/ 1948, at 7 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1948 to 10/26 1948, and that I last saw her alive on 10/26 1948.

Immediate cause of death	Duration
a Atelectasis	
Due to prematurity	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter K. Spelsberg M.D.
Address 1 Franklin Square Date signed 10/27/48

VS 150

8256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

XV G68256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES ROUTZAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden Name K N
15. Birthplace O

16 (a) Informant W
(b) Address N

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed October 11, 1948

VS 151

66857 BALTIMORE CITY HEALTH DEPARTMENT 66857
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. 2nd Ave Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Bayne
3 (b) If veteran, name war: U.S. Navy Enlistee
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of ~~husband~~ wife: Gladys Edwards
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): 2-13-05
8. AGE: Years 43 | Months 8 | Days 19 | If less than one day hr. min.
9. Birthplace: Pa. (Town, county, and state)
10. Usual Occupation: Clerk (Civilian)
11. Industry or business: U.S. Maritime Comm.
FATHER 12. Name: Samuel E. Bayne
13. Birthplace: Md
MOTHER 14. Maiden Name: Fannie James
15. Birthplace: Md
16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory: Prospect Hill Cem. Location: Towson, Mary Md
18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Md.
19 (a) (Date rec'd by registrar) (b) (Registrar)

NOV 3 1948

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov 2 1948, at 8 50 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 2 1948, and that I last saw h~~im~~ alive on Nov 2 1948.

Immediate cause of death: Myocardial infarction — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. S. Holmes M. D.
Address Johns Hopkins Date signed 11/2/48

8-7899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 1803
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT A. RUNKLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Josephine Runkles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1881

8. AGE: Years 67 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Frederick Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph H. Runkles
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Cashour
15. Birthplace Md.

16 (a) Informant: Mr. Frank Gardner
(b) Address Mt. Airy, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Prospect Cemetery
Location Frederick Co., Md.

18 (a) Funeral director E. M. Waltz
(b) Address Emmitsburg, Md.

19 (a) NOV 4 1948 (Date received by registrar) (b) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 12:10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. M. Ruth M.D. (Medical Examiner)

Date signed 11/3/48

VS 151

668259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Glen Rogers
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira W. Davis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) 1-21-87
8. AGE: Years 61 | Months 9 | Days 12 | If less than one day: hr. min.
9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER 12. Name Albert Davis
13. Birthplace Va
MOTHER 14. Maiden Name Laura Cook
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Sunset Mem. Cem
Location Beckley W. Va.
18 (a) Funeral director Tom Cook Inc
(b) Address 217 S. Paul St
19 (a) (Date received by registrar) NOV 4 1948 (b) Huntington W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948 at 3 P M
21. I certify that death occurred on the date above stated, that I attended deceased from 9-29 1948 to 11-3-1948 and that I last saw him alive on 11-3-1948.

Immediate cause of death: Suppurative Pancreatitis — Duration: 9 wks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct 5, 1948.
Major findings of operation: Peri-pancreatic abscess; Oct 22 - Exploration of ~~surgery~~ under diaphragm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Vandeleman M.D.
Address The Johns Hopkins Hosp. Signed 11.3.48

VS 150

G68260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VIOLET L RISTON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	White	Married

6 (b) Name of husband or wife Franklin B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 8, 1896

8. AGE: Years	Months	Days	If less than one day hr.	min.
52	2	25		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | 12. Name Will Fox
FATHER | 13. Birthplace Unknown

MOTHER | 14. Maiden Name Ada (Unknown)
15. Birthplace Baltimore, Md.

16 (a) Informant Boris R. Durrett
(b) Address JOHNS HOPKINS HOSPITAL Chilesburg, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1948, to Nov. 1948, and that I last saw her alive on Nov. 1948

Immediate cause of death	Duration
Due to Glioblastoma, right temporal lobe	6 mos +
Due to	
Other Conditions Chalecystitis chronic	

(Include pregnancy within 3 months of death)

Date of operation May 1945.
Major findings of operation: Glioblastoma
(Craniotomy)
of autopsy: 3 Nov. 1948

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.
23. Signature Irvin F. Stamburger Sr. M. D.
Address Date signed

VS 190

668261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93d (668261)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Eleanora Ave.
(c) Hospital or institution: 28 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Eleanora Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH C. ANDERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Ellsworth M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1863

8. AGE: Years	Months	Days	If less than one day
85	5	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Daisy A. Kirk
(b) Address 5215 Eleanora Ave.

17 (a) Burial (b) Date thereof 11/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 4 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to Nov. 3 1948 and that I last saw h alive on Nov. 2 1948

Immediate cause of death Congestive Heart Failure

Due to Cerebral Hemorrhage

Due to Hypertension

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) (While at work)
(e) Means of injury

23. Signature. H. T. Trumpott

Address 1623 E. North Ave. Date signed 11/5/48

VS 199

668262

BALTIMORE CITY HEALTH DEPARTMENT ✓ 668262 Registered No.

CERTIFICATE OF DEATH 836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 7717
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Konda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 80 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Jacob Teetelman
(b) Address 1936 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
Address 2410 Gutsav Place

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948, at 11 15 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1948 to 11-3 1948 and that I last saw her alive on 11-3 1948.

	Duration
Immediate cause of death: Cerebral thrombosis	
Due to: General arteriosclerosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Levindale Home Date signed 11-3-48

VS 150

668263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓ Registered No. 668263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days) D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2719 Biddle St Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PAWLIK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

(b) Name of husband or wife Joseph (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Skilonez
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Marie Mozelbas
(b) Address 2709 Llewelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd

18 (a) Funeral director John J. Dicka
(b) Address 2829 Addison St.

19 NOV 4 1948 (Date rec'd by Registrar) Huntington Wilmuse M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/1948, at 3 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18/1948, to 11/3/1948, and that I last saw h alive on 11/3/1948

Immediate cause of death	Duration
Cerebral Embolism	
Due to Arteriosclerotic Heart Dis.	
Due to	
Other conditions Coronary Occlusion Recent	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Fetter M.D.
Address Sinai Hospital Date signed 11/2/48 M. D.

VS 150

668264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

X ✓ 668264 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day + ½ hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED: HARFORD
(a) State Md. (b) County Balto.
(c) City or town Bel Air, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Curtis Roe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife — ?
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1-4-85

8. AGE: Years	Months	Days	If less than one day
63	9	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Md. ?? & Pa. Railroad
11. Industry or business

FATHER
12. Name William Roe
13. Birthplace New York

MOTHER
14. Maiden Name Isabelle Curry
15. Birthplace Maryland

16 (a) Informant Mrs Mary R Holloway
(b) Address Bel Air, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/48 (month) (day) (year)
(c) Cemetery or crematory Deer Creek
Location Chestnut Hill Harford Co., Md

18 (a) Funeral director Joseph T Foster
(b) Address Bel Air Md

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1948, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948 to 11-3 1948, and that I last saw him alive on 11-3 1948

Immediate cause of death	Duration
Coronary Occlusion, acute	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No abnormalities

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hosp Date signed 11/3/48.

VS 150

G68265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓

Registered No. G68265

GH. 124224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 16-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Bentalou ST. Z 16 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Bennett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	D

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22- 1906

8. AGE: Years	Months	Days	If less than one day
42	6	11	hr min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph (D)
13. Birthplace Poland

MOTHER
14. Maiden Name Barbara ?(D)
15. Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof nov 6 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A Ohnmacht
(b) Address 1004 Ridgewood Ave

19 (a) NOV 5 1948 (Date rec'd by registrar) FURNISH THIS INFORMATION IF DECEASED WAS EMPLOYED Huntington Williams, M.D.

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 2- 1948 at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 1 - 1948 to 11- 2- 1948, and that I last saw her alive on 11- 2- 1948

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Left breast	4+ yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1945
Major findings of operation: Carcinoma of Left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E W Kennedy M. D.
Address Balt. City Hosp. Date signed 11/3/48

E. W. Kennedy

VS 190

68266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. 68266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Franklin Square Hospital 18.03
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 34 S. Carlton St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME IDA DEAVER

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife William Deaver
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	3	7	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business .....

FATHER
12. Name Thomas Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Edward J. McMahon
(b) Address 34 S. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month, day, year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 500 W. Lombard St

NOV 4 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 6:20 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature George E. Merrill M.D.
Medical Examiner
Date signed 11/2/48

68267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 H

Registered No. 68267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Parkside Drive.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie) also Mamie E. Schaumburg
Mary)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry R. Schaumburg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1868

8. AGE: Years 79 | Months 11 | Days 17 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Birckhead
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth Swormstedt
15. Birthplace: Md.

16 (a) Informant: Mrs. Bessie Buttner
(b) Address: 710 McKewin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto. Md.

19 NOV 4 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948; at 1 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 2/48 at approx. 7 P.M.
(b) Where did injury occur? 3500 Parkside Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: All burners on the oven but unlit

23. Signature [signature] M.D.
Medical Examiner
Date signed 11/3/48

VS 151

668268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 38218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Sulgrave Avenue
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Sulgrave Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Wolfenden

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Eudora B. Wolfenden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28, 1869

8. AGE: Years	Months	Days	If less than one day
78	11	4	hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)
10. Usual Occupation Asst. Building Supt.
11. Industry or business Johns Hopkins University

FATHER
12. Name Thomas Wolfenden
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Jones
15. Birthplace Maryland

16 (a) Informant Thomas H. Wolfenden
(b) Address 5717 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) [redacted] c'd by [redacted] Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH November 2, 1948, at 12.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948, to Nov. 2 1948, and that I last saw h[illegible] alive on Nov. 2 1948.

Immediate cause of death	Duration
Coronary Occlusion	2 hrs.
Due to arteriosclerosis	
Due to	
Other Conditions Congestive Heart Failure (Include pregnancy within 3 months of death)	3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Ahart M. D.
Address 2601 Maryland Ave. Date signed 11/3/48

VS 150

G 66267
G68269 B.C.-48-2388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Pishnock

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-27-48

8. **AGE:** Years | Months | Days: 5- | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name: John Pishnock
13. Birthplace: Pa

MOTHER
14. Maiden Name: Gertrude Reese
15. Birthplace: Pa

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director: Ford Dickson
(b) Address: Huntington Williams, Md.

19 NOV 4 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948. at 3 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1948 to Nov 1 1948. and that I last saw him alive on Nov 1 1948.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature C. C. Young M. D.
Address Johns Hopkins Hosp. Date signed 11-2-48

VS 150

G68270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G68370 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-0 V
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Brunson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Edward
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) 2-7-95

8. AGE: Years	Months	Days	If less than one day
53	6	23	hr. min.

9. Birthplace Greenville, So Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Wilson
13. Birthplace ? S.C.

MOTHER
14. Maiden Name Marcie Johnson
15. Birthplace SC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. - Md.

18 (a) Funeral director Charles R. Law
1948 Address 802 Mad. Ave.

19 (a) (b) Huntington Williamsport, Md.
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948 at 6 05 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-1 1948 to 11-1 1948 and that I last saw h-- alive on 11-1 1948.

Immediate cause of death Hypoglycemia secondary to hyperinsulinism — Duration

Due to

Due to Cystadenocarcinoma Pancreas Metastatic

Other Conditions ? Cerebral Thrombosis Expired Weakness to Coma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cystadenocarcinoma of Pancreas with Metastases

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Allen Harvey M. D.
Address Johns Hopkins Date signed 11-2-48

1-8

668271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No. 668271

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Manacher

3 (b) If veteran, name war none

3 (c) Social Security Account No. 212-03-9952

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sadie Nee Zerwitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1901

8. AGE: Years 47 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation

11. Industry or business Dyer A. P. Tea Co

FATHER
12. Name Samuel Manacher
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Sadie Manacher
(b) Address 3501 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/1948 at 10 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/1948 to 11/4/1948. and that I last saw h[illegible] alive on 11/4/1948.

Immediate cause of death

Due to Metastatic C.A.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/4/48

Major findings of operation: BRONCHOSCOPY STOMACH Recurrent carcinoma

of autopsy: [illegible] granuloma

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Sinai Hospital Date signed 11/4/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 168272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) //

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Coeburnville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Hearne

3 (b) If veteran, name war / | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-47

8. AGE: Years	Months	Days	If less than one day
1	5		hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Hearne
FATHER 13. Birthplace Indiana

MOTHER 14. Maiden Name Miriam Hearne
MOTHER 15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory W. Laurel Hill
Location Philadelphia, Penna.

18 (a) Funeral director J. E. Tyson
(b) Address Petersburg, Huntingdon Co., Penna.

19 (a) [illegible] (b) Huntingdon Williamsburg, Pa. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948, to 11/3 1948, and that I last saw him alive on 11/3 1948.

Immediate cause of death	Duration
Pulmonary edema	
Due to Cardiac failure	
Due to	
Other Conditions Operation for transposition of the great vessels (Include pregnancy within 3 months of death)	

Date of operation 11-1-48.
Major findings of operation: Transposition of the great vessels
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 11-4-48
M. D.

VS 153

68273

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 163 M

Registered No. 68273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (Va.) Va. (b) County
(c) City or town (Herndon) Herndon (If outside city or town limits, write RURAL and give town)
(d) Street No. (Route #3) (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles ~~E.~~ JUDSON STODDARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mildred A.

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1916

8. AGE: Years	Months	Days	If less than one day
31	11	2	hr. min.

9. Birthplace Washington, D.C. Silver Spring (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Judson Stoddard

13. Birthplace Washington, D. C. DeGhorart

MOTHER 14. Maiden Name Caroline (DeGhorart)

15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Mildred A. Stoddard

(b) Address 2926 Silver Hill Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director E. Willis Lamoreau

(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1948, at 6: P. M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at ? M.

(b) Where did injury occur? Rear of -- 2510 Talbot Road

(c) Did injury occur at home, on farm, industrial place, or public place? Garage While at work? no

(d) Means of injury auto Closed garage -- motor on

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 11-2-48

668274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 668274

16a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5616 Stonington Avenue
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Stonington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND JOHN WILHIDE

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lulu P. Wilhide
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) December 20, 1898

8. AGE: Years	Months	Days	If less than one day
49	10	13	hr. min.

9. Birthplace Walkersville, Md.
(Town, county, and state)
10. Usual Occupation Telephone Switchman
11. Industry or business C & P Telephone Co.

FATHER
12. Name John R. Wilhide
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden Name Fannie Fitz
15. Birthplace Frederick County, Md.

16 (a) Informant Mrs. Lulu P. Wilhide
(b) Address 5616 Stonington Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location nr. Keymar, Md.

18 (a) Funeral director E. WILLIS LA. OREAU
(b) Address 4510 Liberty Heights Avenue

19 NOV 4 1948 (Date rec'd by Registrar) (b) Huntington Woods, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 19 48 at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Unmitted fracture of right femur.
Cerebral edema
Due to Syphilitic aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-48 at ? M.
(b) Where did injury occur? Outside 5616 Stonington Avenue
(c) Did injury occur at home, on farm, industrial place, public place? outside home While at work? No
(d) Means of injury Fell from ladder

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/3/48

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G68275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G68275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 Wayne Ave.
(c) Hospital or institution: 2807

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Wayne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Brown Macnab

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Helen M. Macnab
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	24	hr. min.

9. Birthplace Scotland (Creiff)
(Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business Self

MOTHER / FATHER
12. Name Archibald Macnab
13. Birthplace Scotland

MOTHER
14. Maiden Name Jean Brown
15. Birthplace Scotland

16 (a) Informant Mr. Robert Macnab
(b) Address 5505 Wayne Ave.

17 (a) Burial (b) Date thereof Nov. 5, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Glyn Md.

18 (a) Funeral director Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 4 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Oct. 1948 to 3 Nov. 1948, and that I last saw h[illegible] alive on 3 Nov. 1948.

Immediate cause of death Pulmonary supprendial infarction — Duration 3 days

Due to Antherosclerotic hypertensive cardiovascular disease — Duration 5 yrs +

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Preston St. Date signed Nov 4 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

G68276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ingram Hall Apts.
(c) Hospital or institution: 47-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ingram Hall Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARGUERITE BROWN BAER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis B. Baer.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1889.

8. AGE: Years	Months	Days	If less than one day
59	4	14	hr. min.

9. Birthplace Cincinnati, Ohio. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Daniel F. Brown,
13. Birthplace Cincinnati, Ohio.

MOTHER
14. Maiden Name Miriam Klopfer,
15. Birthplace Cincinnati, Ohio.

16 (a) Informant Mr. Louis B. Baer,
(b) Address Ingram Hall Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Burial Association of Balto.
(b) Address 1902 Eutaw Place.

19 NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 2nd. 1948, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1948 to Nov 2 1948 and that I last saw her alive on Nov 2 1948.

Immediate cause of death	Duration
Coronary occlusion	1 hr
Due to Coronary Sclerosis	1 year
Due to Generalized Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmanuel Klopfer M.D.
Address Esplanade Apts. Date signed 11/3/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68277

BALTIMORE CITY HEALTH DEPARTMENT 93 ✓ G68277
Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3323 Hudson St.
(c) Hospital or institution: 76-11.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward P. Blank.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Margaret D. Blank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-31-1877

8. AGE: Years	Months	Days	If less than one day
71	0	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore City Worker

FATHER
12. Name John B. Blank
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Blank
15. Birthplace Ireland.

16 (a) Informant Edward P. Blank Jr.
(b) Address 3323 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Edmondson Ave.

18 (a) Funeral director Charles J. Feeley
(b) Address 904 S. Conkling St.

19 (a) NOV 9 1948 (b) Registered
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 2 - 1948 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1946 to Nov 2 1948 and that I last saw h[illegible] alive on Oct 31 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardiac Decompensation	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Flanigan Jr. M. D.
Address 3503 Fait Ave Date signed 11-3-48

G68278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave & Dakeland St.
(c) Hospital or institution: West Baltimore General Hosp. 9-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Ensor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick J. Dolan

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Julia Dolan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1895

8. AGE: Years	Months	Days	If less than one day
53 yrs	8 mos	28 ds	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Industrial Building Co.

FATHER
12. Name Michael Dolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Quigan
15. Birthplace Ireland

16 (a) Informant Mrs. Julia Dolan
(b) Address 1303 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location 4300 Old Frederick Rd

18 (a) Funeral director Eugene A. Conklin
(b) Address 924 E. Eager St.

19 (a) NOV 4 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1948, at 3 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948, to 11/4 1948, and that I last saw h/m alive on 11/4 1948.

Immediate cause of death: Bleeding Esophageal varices
Due to: Portal Cirrhosis
Due to:
Other Conditions: Bilateral ind. inguinal hernia (Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Teicher M. D.
Address 1000 Eutaw Pl. Date signed Nov 4, 1948

Please type or print plainly. Physicians: please write the causes of death clearly and legibly.

VS 150

X ✓ G68279

G68279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 115 days

(e) Length of stay in Baltimore (yrs., mos., or days): 115 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: NJ (b) County:

(c) City or town: Mt. Ephraim (If outside city or town limits, write RURAL and give town)

(d) Street No.: 20 Thompson Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3 (a) FULL NAME: NATHAN HENDRICKSON LORE

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 221-10-9198

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ?

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1860

8. AGE: Years: 88 Months: 7 Days: 16 If less than one day: hr. min.

9. Birthplace: Newport, NJ (Town, county, and state)

10. Usual Occupation: Master pilot

11. Industry or business: Seafarer

FATHER 12. Name: Louis R. Lore

FATHER 13. Birthplace: Newport, NJ

MOTHER 14. Maiden Name: Mary E. Price

MOTHER 15. Birthplace: Martin, NJ

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial, cremation, or removal: Cremated (b) Date thereof: 11/4/48 (month) (day) (year)

(c) Cemetery or crematory: F. O. P.

Location: Lexington, Ky.

18 (a) Funeral director: Williams Co. Inc.

(b) Address: 1217 E. Fort Ave.

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams, W.Va.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH: Nov. 4 1948, at 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 12 1948 to Nov. 4 1948, and that I last saw him alive on Nov. 4 1948.

Immediate cause of death: Cholecystitis and cholelithiasis postoperative — Duration: 1 yr.

Due to:

Due to:

Other Conditions: Jaundice

(Include pregnancy within 3 months of death)

Date of operation: 10/25/48

Major findings of operation: Large stone occluding common bile duct

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon

Address: Clinical Director Date signed: 11/4/48 M.D.

X

G68280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G68280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2639 E. Madison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANGIOLINA MARIA SARAULLO

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank Saraullo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1893

8. AGE: Years	Months	Days	If less than one day
54 yrs.	11	2	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rafaele Scagliarini
13. Birthplace Italy

MOTHER
14. Maiden Name Luigia Puluzzi
15 Birthplace Italy

16 (a) Informant Mr. Frank Saraullo – husband
(b) Address 2639 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (Delivered by ...) (b) [illegible] Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Nov. 2 1948, and that I last saw h[illegible] alive on Nov 2 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia	10/31/48
Due to Carcinoma of Rectum with Metastasis	1/1/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rybarek M.D.
Address 801 s Kenwood Ave Date signed 11/2/48

RIMBACH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G68281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reynor Ave + Dukeland St.
(c) Hospital or institution West Baltimore General No 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 Willard St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Rimbach

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George Rimbach

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 28, 1864

8. AGE: Years 84 | Months 7 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER
12. Name Wiskow
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Alois Ernest Rimbach
(b) Address 142 Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schnabel
(b) Address 2101 N. Edmondson Ave. Washington Boulevard

19 (a) 5 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948, to Nov. 3 1948, and that I last saw h[illegible] alive on Nov. 3 1948.

Immediate cause of death, Adenocarcinoma of pancreas with generalized abdominal carcinomatosis — Duration 6 mos.

Due to

Due to

Other Conditions Arteriosclerotic Cardiovascular Disease (Include pregnancy within 3 months of death)

Date of operation Oct. 27, 1948

Major findings of operation: Same

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein, M.D.
Address West Balto. Gen. Hosp. Date signed 11/3/48

VS 100

8282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a2

Registered No. 668282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSPITAL 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 15 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 PARK HEIGHTS AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. HARRY Odell FARLEY
3 (b) If veteran, name war
3 (c) Social Security Account No. 220-20-2298

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
M	W	

6 (b) Name of husband or wife MRS. Ida FARLEY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Dec 17-1844

8. AGE: Years	Months	Days	If less than one day
58	10	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name ? Farley
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Justice
15. Birthplace Va

16 (a) Informant Mrs Ida C Farley
(b) Address 5001 Park Heights Ave

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul St Huntington Williams, Md

19 (a) NOV 5 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 . at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 . to 11/4/48 19 .
and that I last saw him alive on 11/4/48 19 .

Immediate cause of death Heart failure — Duration

Due to Coronary Thrombosis

Due to Peripheral vascular Collapse

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(Specify type of place)
(e) Means of injury

23. Signature William B. Wonach M D
Address BON SECOURS HOSP. Date signed 11/4/48

VS 150

8283 XV G68283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: HARFORD
(a) State Md. (b) County Co
(c) City or town Edgewood.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY THARP

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Donald.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) about 1906

8. AGE: Years 42 | Months | Days | If less than one day: hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Monroe Yordy
13. Birthplace Pa

MOTHER 14. Maiden Name Mary Zimmerman
15. Birthplace Pa.

16 (a) Informant Donald Tharp
(b) Address Edgewood Md.

17 (a) Removal (b) Date thereof 11/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sunbury
Location Wm Penn Cook Inc

18 (a) Funeral director
(b) Address 217 E. Saint Paul St

19 (a) NOV 5 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 12 [illegible]

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Nov. 5 1948 and that I last saw h[illegible] alive on Nov. 5 1948.

	Duration
Immediate cause of death Cardiac failure & respiratory failure	
Due to Anemia	
Due to Cirrhosis Alcoholic Cirrhosis	
Due to Hypertension	
Other Conditions Diabetes Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. White M. D.
Address University Hosp. Date signed 11-5-48

VS-153

8284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 668284
Registered No.

937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Johns Hopkins Hospital 3-0✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 E. Lombard
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME GEORGE THOMAS SKIPPER 22748

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-2

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace UN KN (Town, county, and state)
10. Usual Occupation Own
11. Industry or business

FATHER
12. Name U
13. Birthplace N K

MOTHER
14. Maiden Name N
15. Birthplace O W N

16 (a) Informant.....
(b) Address.....

17 (a)..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School OCT 27 1948
18 (a) Funeral director Commissioner of Health
(b) Address NOV 5 1948
19 (a)..... (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948, at 10:20 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury.....

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10/11/48

668285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 668285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 N. Lakewood Ave
(c) Hospital or institution: 6-0 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislawa Elizabeth Kaminsky

3 (b) If veteran, name war

3 (c) Social Security Account No 212 16 3636

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wladyslaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56	—	—	hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Zamuski
13. Birthplace Poland

MOTHER
14. Maiden Name Wolk
15. Birthplace Poland

16 (a) Informant Gregory Kaminski
(b) Address 124 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) NOV 5 1948 (b) Huntington Williams M.D. (Deputy Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Nov. 1948, at 9:17 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammond, Jr. M.D. Medical Examiner.
Date signed 3 NOV. 48

VS 151

8286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68286 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosie Schmuckler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 71 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden Name: Jennie
15. Birthplace: Russia

16 (a) Informant: Louis Schmuckler
(b) Address: 3816 Towanda Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Hebrew Lunt

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2400 Eutaw Place

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 — 4 — 1948 at 7:30 M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 30 1948 to Nov 4 1948 and that I last saw h[illegible] alive on Nov 4 1948

Immediate cause of death: Coronary Thrombosis — Duration: Instant

Due to: Arteriosclerosis & Cardiac Failure — 6 mo.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Benton M. Kalman M.D.
Address: 3700 Park Heights Ave Date signed: Nov 5 1948

VS 150

X

68287 ✓ G68287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Narcissus Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Goldsmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1884

8. AGE: Years	Months	Days	If less than one day hr.	min.
64				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name not known
13. Birthplace Poland

MOTHER
14. Maiden Name not known
15. Birthplace Poland

16 (a) Informant Lena Goldsmith
(b) Address 800 Narcissus Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Herring Run

18 (a) Funeral director Isaac Kerbis Inc
(b) Address 206 Eutaw Place

19 (a) (b) Washington Philadelphia
(Date received by registrar) NOV 5 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948 at 4:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1 1948 to November 5 1948 and that I last saw h[illegible] alive on November 5 1948

Immediate cause of death Myocardial Infarction — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.M. Silverstein M. D.
Address Sinai Hospital Date signed 11-5

VS 153

C.M. Silverstein

68288

ES-123775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. 68288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS 7-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Rosenthal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 26, 1884

8. AGE: Years	Months	Days	If less than one day
64	3	5	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

PARENTS
12. Name John Dominick (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Shorhart (D)
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Edmondson Ave & Hilton Road

18 (a) Funeral director J. J. Foley & Sons
(b) Address 218 Light St

19 NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948 to 10-31 1948 and that I last saw her alive on 10-31 1948

Immediate cause of death Carcinomatosis

Due to adeno carcinoma of Colon

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9-14-18-20-48

Major findings of operation: Carcinomatosis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Mowitz M. D.
Address Balto. City Hosp. Date signed 11/3/48

VS 150

G68289

ES-29423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G68289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 or 1328 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Merryman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Albertus (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	2	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Augustus Shue (D)
13. Birthplace Norway

MOTHER
14. Maiden Name Matilda Johnson
15. Birthplace Norway

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burnie (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Baltimore & Hill Road

18 (a) Funeral director J. J. Foley & Sons
(b) Address 1318 Light St.

19 (a) Nov 5 1948 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1937 to 10-30 1948 and that I last saw her alive on 10-30 1948

Immediate cause of death Cerebral vascular accident c left hemiparesis — Duration 2 days

Due to Hypertensive arteriosclerotic cardiovascular disease

Due to

Other Conditions Bronchopneumonia — Duration 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Maurice M. D.
Address Balto City Hosp Date signed 11-3-48

VS 153

X

Medical Examiner's Case
Case Released To Hospital

668290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 668290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 752, Popular Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert L. Schaaf Herbert Linwood Schaaf

3 (b) If veteran, name war

3 (c) Social Security Account No. 227-16-4465

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma Schaaf
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept 3 - 1889

8. AGE: Years	Months	Days	If less than one day
59	2	1	hr. min.

9. Birthplace Richmond Va (Town, county, and state)
10. Usual Occupation Repair man
11. Industry or business Hobby Shop

FATHER
12. Name John B. Schaaf
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Julia Jordan
15. Birthplace U. S.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem
Location Richmond, Va.

18 (a) Funeral director E. Nelly Lamoreau
(b) Address 4510 Liberty Heights

19 (a) NOV 5 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 6.35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1948 to 11-4 1948.
and that I last saw h alive on 11-4 1948.

Immediate cause of death Necrosis of almost all of small bowel — Duration

Due to ? embli, ? toxin

Due to

Other Conditions Arteriosclerosis & Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: gangrene of small bowel

of autopsy: Enlarged left ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.D. Jackson M.D.
Address The J. H. H. Date signed 11/5/48

VS 150

Medical Examiner's Case - certificate to be Approved 123

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 N. Bond St
(c) Hospital or institution: 8.07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-6442

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22-1898

8. AGE: Years 49 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Saluda Co. S.C. (Town, county, and state)

10. Usual Occupation Sales

11. Industry or business

FATHER 12. Name Carroll Smith

FATHER 13. Birthplace Saluda Co. S.C.

MOTHER 14. Maiden Name Ida Wilson

MOTHER 15. Birthplace Saluda Co. S.C.

16 (a) Informant Beatrice Smith

(b) Address 1125 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus Md

18 (a) Funeral director Tofat L. Williams

(b) Address 1565 McElderry St

19 (a) [illegible] (b) [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1948 at 7:30 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Nov 2 1948, and that I last saw him alive on Nov 2 1948.

Immediate cause of death: Carcinoma of Stomach with Pyloric Obstruction — Duration: 6 mos

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young, M.D.

Address 1424 E Monument St Date signed 11/4/48

PHYSICIAN — Underline the cause to which death should be charged statistically.

VS 130

G68292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68292
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX HERMAN PAULUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	M	W	Married

6 (b) Name of husband or wife Caroline G. Paulus
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr) July 21, 1860

8. AGE: Years	Months	Days	If less than one day
88	3	14	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Plumbers Supply Co.

FATHER
12. Name Herman Paulus
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Baumgartner
15. Birthplace Germany

16 (a) Informant Mrs. Caroline C. Paulus
(b) Address 1538 N. Broadway

17 (a) Burial (b) Date thereof 11/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Riverview Cemetery
Location Wilmington, Delaware

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 5 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Nov. 4 1948, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1942 to Nov. 4 1948, and that I last saw h alive on Nov. 3 1948.

Immediate cause of death Coronary Occlusion — Duration 40 Hours

Due to Arteriosclerosis (Generalized)

Due to

Other Conditions Mental Deterioration — 10 years
Diabetes Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Grafton Hershey M.D.
Address 214 Medical Arts Bldg Date signed 11/4/48

VS 1-49

G68293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68293

G68293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Wyndhurst Avenue
(c) Hospital or institution: 2211

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Wyndhurst Avenue (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME James Francis McCabe, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leila Post
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) August 5, 1875

8. AGE: Years	Months	Days	If less than one day
73	2	29	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name James F. McCabe
13. Birthplace Havre De Grace, Md.

MOTHER
14. Maiden Name Gertrude Knight
15. Birthplace Cecil County, Md.

16 (a) Informant Mrs. James F. McCabe, Jr.
(b) Address 206 Wyndhurst Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans, Md.

18 (a) Funeral director H. W. Means and Son
(b) Address 805 N. Calvert Street

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Registrar

Remington for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4th 1948, at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Nov. 5th 1948, and that I last saw him alive on Nov. 3rd 1948

Immediate cause of death Coronary artery disease

Due to Arteriosclerosis

Due to

Other Conditions Hemiplegia due to old injury.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ——

of autopsy: None

Duration
six months
several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward E. Chatard M. D.
Address 1300 N. Calvert St. Date signed 11-4-48

X

G68294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G68294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E. Mt. Vernon Place
(c) Hospital or institution: none 11-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E. Mt. Vernon Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Priscilla Richardson Grafflin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Daniel A. Grafflin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7, 1901

8. AGE: Years	Months	Days	If less than one day
47	8	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Thomas Richardson
13. Birthplace Snow Hill, Maryland

MOTHER
14. Maiden Name Margaret Bonneville
15. Birthplace Snow Hill, Maryland

16 (a) Informant Mrs. Lawrence Clark
(b) Address 1701 Sulgrave Ave.

17 (a) Burial (b) Date thereof 11/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore

NOV 5 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Apr. 1948 to 3 Nov. 1948 and that I last saw h[illegible] alive on 3 Nov. 1948

Immediate cause of death	Duration
Cancer of breast with multiple metastases	3 yrs.
Due to	
Due to	
Other Conditions Healed tuberculosis	18 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis E. Wice, M.D.
Address 920 St. Paul St. Date signed 5 Nov. '48

668295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 96452

Registered No. G68295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Clairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife ALICE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 28- 1877

8. AGE: Years	Months	Days	If less than one day
71	5	4	hr. ; min.

9. Birthplace PA.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Jones
15. Birthplace PA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Ferrill Della Rose
(b) Address 322 S. High St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 1 - 19 48 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 3- 19 45 to 11-1 - 19 48 and that I last saw him alive on 11-1- 1948

Immediate cause of death Cardiac failure — Duration

Due to arteriosclerotic heart disease

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Warren
Address Balto. City Hosp. Date signed 11-9-48

VS 150

8296 BALTIMORE CITY HEALTH DEPARTMENT X V G68296

BC-48-22775 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 435 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Higdon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	3 hr. 6½ min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Franklin Higdon
13. Birthplace Balto Md

MOTHER 14. Maiden Name Violet Marie Phelps
15. Birthplace Severn Md

16 (a) Informant Mrs Violet Higdon
(b) Address Box 435 Brooklyn 25 Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 3 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 5 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1948 to 10/30 1948, and that I last saw h[er] alive on 10/30 1948.

Immediate cause of death	Duration
(a) Prematurity	
Due to (b) Atelectasis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy: Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Levin MD
Address [redacted] Date signed 11/1/48

VS 150

68297

M. - 7769

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 68297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Will Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? 1884

8. AGE: Years	Months	Days	If less than one day
64 ?			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Faunke
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948, at 11.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1942, to Oct. 26 1948, and that I last saw h im alive on Oct. 26 1948.

Immediate cause of death Heart failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David A. Marine M. D.
Address Balto City Hosp Date signed 10-28-48

VS 150

68298

ES-123994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 727

Registered No. 668298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Brunk (Brunt) St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Parsons.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1905

8. AGE: Years	Months	Days	If less than one day
43	3	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Berrnett
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Dorsey
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 19 48 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 19 48 to 10-23 19 48 and that I last saw her alive on 10-23 19 48

Immediate cause of death: Pul edema-myocardial failure ?
Due to ?
Due to
Other Conditions 2° anemia
Vit deficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson
Address BCH Date signed 10-28 M.D.

VS 189

111c

668299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 c.

668299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 7-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Tyndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM ALBERT POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna L. Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1917

8. AGE: Years	Months	Days	If less than one day
31	7	28	hr. min.

9. Birthplace Wilmington, Delaware (Town, county, and state)
10. Usual Occupation Photographer
11. Industry or business

FATHER
12. Name Hartley Powell
13. Birthplace New Jersey

MOTHER
14. Maiden Name Pearl Shoemaker
15. Birthplace Unknown

16 (a) Informant Mrs. Anna L. Powell
(b) Address 3211 Tyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director Ullrich Funeral Home.
(b) Address 2008 Orleans St.

19 (a) [redacted] (b) Huntingtown, Maryland
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nove. 4, 1948, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 3/48 at approx. 7 P.M.
(b) Where did injury occur? 3211 Tyndale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 11/4/48

G68300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68300 Registered No. 24742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 327 W. Biddle St.
(c) Hospital or institution: 11 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 327 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lindsay Ayers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Sarah Bendy Ayers
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
74?	?	?	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Ayers.
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Henry F. Ayers
(b) Address 327 W. Biddle St.

17 (a) Burial (b) Date thereof 11-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Mrs Frances A. Hensley
(b) Address 518 W Biddle St

19 (a) NOV 5 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to 19 , and that I last saw him alive on Nov. 4 1948

Immediate cause of death Cerebral Hemorrhage — Duration 1 day
Due to Arterio-sclerosis. — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work)
(e) Means of injury

23. Signature R B Eyestone M. D.
Address 501 Cherry Hill Rd. Date signed

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

068301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 068301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Bentley Ave
(c) Hospital or institution: 1035 Bentley Ave Heart
(d) Length of stay in hospital or institution: (yrs., mos., or days) 9 years
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Bentley Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Viola Morris (alias Morris)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife Benjamin Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-93?

8. AGE: Years	Months	Days	If less than one day
55		14	hr. min.

9. Birthplace Eastern Shore
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Johns
13. Birthplace Unknown Eastern Shore?

MOTHER
14. Maiden Name Carrie Johns
15. Birthplace Unknown?

16 (a) Informant Edward Grafton Johns (SON)
(b) Address 1035 Bentley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Nov 6 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1948 to Nov 3 1948, and that I last saw h SR alive on Nov 2 1948.

Immediate cause of death	Duration
Hemorrhage	
Due to Carcinoma of Uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Russell M. D.
Address 301 Penna Ave Date signed Nov 3/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G68302 Registered No.

B-123521 46B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. Crownsville State Hospital (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Washington Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 18, 1880

8. AGE: Years 68 | Months 1 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaih ?

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Millie Thompson (D)

MOTHER 15. Birthplace Md.

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 5 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 10-20 1948 at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1948 to 10-20 1948, and that I last saw h in alive on 10-20 1948.

Immediate cause of death ~~d~~ Malnutrition — Duration Weeks

Due to Carcinoma of Stomach — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 15/10/1947

Major findings of operation: Carcinoma of Stomach

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman Cole M.D. M. D.

Address 4940 Eastern Ave Date signed 10/28/48

VS 150

68303

ES-122584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 68303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owan Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	26	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pat Dougherty
13. Birthplace Mass.

MOTHER
14. Maiden Name Emma Woods
15. Birthplace W. Va.

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 5 1948 (Date rec'd by registrar) (b)

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 1948 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1948 to 10-21 1948 and that I last saw him alive on 10-21 1948

Immediate cause of death: Probable Coronary occlusion — Duration: 3 days

Due to arteriosclerosis

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Verlenden M.D.

Address Balto City Hosp Date signed 28 Oct 48

92a

Medical Examiner's Case

668304 ✓ 668304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3037 Guilford Ave

(c) Hospital or institution: 12-C ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)

(d) Street No. 3037 Guilford Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine A. McBride ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. H. McBride

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	9	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name ? Keyhan

13. Birthplace ?

14. Maiden Name Ann Jones

15. Birthplace Maryland

16 (a) Informant Mrs. W. M. Wilhelm

(b) Address 3037 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director John A. Moran

(b) Address 3906 E. Baltimore St

19 NOV 5 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1948 at 10 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Nov 1948

and that I last saw her alive on Nov 3rd 1948

Immediate cause of death Bronchopneumonia — Duration 4 days.

Due to Contusions of face & nose; fracture of right femur

Due to

Other conditions Arteriosclerotic Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

CERTIFICATION APPROVED BY Wm. H. Kammer, M.D.

per Thomas J. Mullen M. D.

CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence Oct 29, 1948 at 8 00 A M

(c) Where did injury occur? Baltimore Maryland - 18 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fell over a Chair

23. Signature William S Helfrid

Address 5006 Roland Ave Date signed 11/4/48 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 N Bentley St
(c) Hospital or institution:
6-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 N. Bentley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter S. Wisnowskey (Wisniewski)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-3703

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Antonette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 26 1893.

8. AGE: Years	Months	Days	If less than one day
55	1	7	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Simon Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Antonette Wisnowskey
(b) Address 36 N Bentley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John G. Moran
(b) Address 3000 Baltimore St

19 (a) NOV 5 1948 (Date rec'd by registrar) Thurlow Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948 at 6 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 20 1948 to Nov. 3 1948. and that I last saw him alive on Oct 26 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Artery Thrombosis	
Due to Arteriosclerosis Coronary Artery	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Flanigan M.D.
Address 3563 Fait Ave Date signed 11-3-48

68306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Register No. 68306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5104 Whitford Ave
(c) Hospital or institution:
77-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 Whitford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phebe L. Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N.	Widowed

6 (b) Name of husband or wife Gus Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1857 ?

8. AGE: Years	Months	Days	If less than one day
91 ?	2	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Maxwell
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. E. Kirby Lynch
(b) Address 5104 Whitford Ave

17 (a) Burial (b) Date thereof 11-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave & Oliver St

18 (a) Funeral director John G. Moran
(b) Address 3009 E. Baltimore St

19 (a) NOV 5 1948 (b) Huntington Williams
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1948, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 11/3 1948, and that I last saw her alive on 11/3 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	?
Due to Arteriosclerosis	?
Due to	
Other Conditions Cerebral Stem.	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lewis H. Carlson M. D.
Address 2520 Talbot Rd. Date signed 11/5/48

VS 150

68307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 E. Fort Ave
(c) Hospital or institution: 24-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa A. Kemp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Henry C. Kemp. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 15-1877

8. AGE: Years 71 | Months - | Days 14. | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business Housework

FATHER
12. Name James P. Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name ? Welsh
15. Birthplace Ireland

16 (a) Informant Mrs Anna T. Lewandowski
(b) Address 1408 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

NOV 5 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1948, at 2.30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to 1947, and that I last saw alive on 19..

Immediate cause of death: Arteriosclerosis Cerebral Vascular Disease — Duration 3 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Brenson M. D.
Address 107 S. West Date signed Nov 5, 1948

VS 152

308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68308

110a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days (23 hrs)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1277 East North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET CATALANO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Salvatore Catalano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1920

8. AGE: Years	Months	Days	If less than one day
28	3	29	hr. min.

9. Birthplace Braddock, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Zeck
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Suder
15. Birthplace Austria

16 (a) Informant Salvatore Catalano (husband)
(b) Address 1277 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore

18 (a) Funeral director Frank Della Noce
(b) Address 322 S. High St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 2.00PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Embolism, Left
Due to Rheumatic heart disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed November 4, 1948

VS 151

68309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G68309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 853 W Lexington
(c) Hospital or institution: 1601
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5 [illegible]

8. AGE: Years 63 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, County, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER 12. Name John Chester
13. Birthplace Balto Md

MOTHER 14. Maiden Name Annie Jones
15. Birthplace Balto Md

16 (a) Informant Hilda Collins
(b) Address 853 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaac H Brown Son
(b) Address 106 W Montgomery St

19 NOV 5 1948 (Date rec'd by Registrar) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1948 to Nov 1 1948 and that I last saw h alive on Nov 1 1948.

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 533 Woodlawn Ave Date signed 11-3-48

VS 180

68310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Edgewood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LULA MAE HANSROTE

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Lawrence

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1885

8. AGE: Years: 63 Months: 5 Days: 11 If less than one day: hr. min.

9. Birthplace: Pea Hill, Va. (Town, county, and state)

10. Usual Occupation: Saleslady

11. Industry or business: Hub Depa rtment Store

FATHER
12. Name: (Unknown) Guthridge
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Sarah (Unknown)
15. Birthplace: Unknown

16 (a) Informant: Adam Ha nsrote
(b) Address: 2426 14th ST. NW, Washnington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Fort Lincoln
Location: Washington D.C.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1948, at 12 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947 to 11/3 1948 and that I last saw her alive on 11/1 1945

	Duration
Immediate cause of death: Cerebral Hemorrhage	11/3/45
Due to Hypertensive Cardio-vascular Disease	1 yr +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature [signature] M.D.
Address 3629 Edmondson Date signed 11/4/45

VS 150

8311 BC-HP-22678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

✓ G68311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROLAND YOUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1948

8. AGE: Years	Months	Days	If less than one day
		21	24 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Ernest Young
13. Birthplace Approx. N.

MOTHER 14. Maiden Name Doris E. Young
15. Birthplace Balto. M.

16 (a) Informant John Ernest Young
(b) Address 1017 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Robert A. Elliott Dght.
(b) Address 1129 N. Caroline st.

19 NOV 5 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Laceration of Jugular Vein

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 7/4
(a) Date of injury Nov. 3/48 approx. 3:55 A.M.
(b) Where did injury occur? 1017 N Gay St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Razor

23. Signature Medical Examiner. M.D.
Date signed

X

68312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163

Registered No. 68312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OPLIN McINTOSH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1917

8. AGE: Years: 31 | Months: 1 | Days: 1 0 | If less than one day: hr. min.

9. Birthplace: Saluda Co., South Carolina
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Thadius McIntosh
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: E. Brooks
15. Birthplace: South Carolina

16 (a) Informant: Holland Funeral Home
(b) Address: Lancaster, South Carolina

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory: Lancaster
Location: Lancaster, South Carolina

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul St.

NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948 at 5 P.M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Self-inflicted gunshot wound

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 3/48 at approx. 4 P.M.
(b) Where did injury occur? 1017 N. Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: burners on, but unlit

23. Signature: [signature] M.D. Medical Examiner.
Date signed 11/4/48

VS 151

68313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 12a

Registered No. G68313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2734 Guilford Ave.
(c) Hospital or institution:

12-02

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE MAY QUARNGESER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife: Henry Quarngeser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1872

8. AGE: Years	Months	Days	If less than one day
76	2	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Stewart
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ellingsworth
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. E. S. Quarngeser
(b) Address Bush & Hamburg Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Remington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov 5 1948
and that I last saw her alive on Nov 4 1948

Immediate cause of death	Duration
Cerebral Hemmorhage	
Due to arterio Sclerosis	
Due to Chronic Glomerulonephritis	
Other Conditions Senility - Anemia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Hamman Blvd Date signed 11/6/48

VS 150

68314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 68314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Lanvale
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E Read St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE, GERTRUDE KIEHNE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-03-4928

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife: Charles W. Kiehne, Sr.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 10-10-1900

8. AGE: Years 48 | Months 0 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual Occupation: Receptionist

11. Industry or business: State Employment Office

FATHER
12. Name: Harry H. MacLellan
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Nellie M. Jones
15. Birthplace: Rochester N. Y.

16 (a) Informant: Mr. Charles W. Kiehne, Jr. son
(b) Address: 1220 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3- 1948 at 11 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948 to 11-3-1948 and that I last saw her alive on 11-3- 1948.

Immediate cause of death: Cardiac failure

Due to: Anemia

Due to: Hypertension Arterio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Nephrosclerosis, Neoplasm? of pancreas

Duration: 3 mos.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. Rowell, Jr. M. D.
Address: Mercy Hospital Date signed 11-7-48

921

VS 180

G68315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G68315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 E. 26th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE E. REYNOLDS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Collin H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 28, 1888

8. AGE: Years 60 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John M. Kaufman
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary C. Minnick
15. Birthplace: Balto., Md.

16 (a) Informant: Collin H. Reynolds
(b) Address: 42 E. 26th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948, at 12:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull & intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/6
(a) Date of injury Nov. 5, 48 at 12:30 A. M.
(b) Where did injury occur? Charles & 24th St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public While at work? No
(d) Means of injury: Ped. & Auto (Struck by)

23. Signature [illegible] M.D. Medical Examiner

Date signed 11/5/48

VS 151

68316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 68316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Wilkens ave.
(c) Hospital or institution: 25-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Wilkens (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Elizabeth Leaf

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. Leaf deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/67

8. AGE: Years 81 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frederick Abel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Weidler
15. Birthplace Germany

16 (a) Informant Mrs. Walter Berryman
(b) Address Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Randallstown, Md

18 (a) Funeral director Frank H. Sewell
(b) Address Pikesville, Md

NOV 5 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1948 at 9:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948 to Nov 4, 1948 and that I last saw h.. alive on Nov. 4, 1948

Immediate cause of death	Duration
Acute congestive failure	
Due to, Hypertension Cardio-vascular disease	
Due to	
Other Conditions Spasmodic aphasia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis R. Mayer
Address 4335 Park Heights Ave Date signed 11/5/48

VS 130

X

68317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V

Registered No. 68317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Underwood Rd.
(c) Hospital or institution: (at home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford.
(c) City or town Bel-Air (If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Box-205 (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country Canada.

3 (a) FULL NAME Ernest Lawrence Dinning

3 (b) If veteran, name war none

3 (c) Social Security Account No. 217-18-1583

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Norah L. Dinning (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan-4-1874

8. AGE: Years 74 | Months 10 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Quebec-Canada (Town, county, and state)

10. Usual Occupation Manfr.

11. Industry or business (Diversified)

FATHER 12. Name Henry Dinning

13. Birthplace Ireland

MOTHER 14. Maiden Name Etta Carpenter

15. Birthplace Canada.

16 (a) Informant E. L. Dinning - Sr. (Son)
(b) Address Hollins Rd-Ely 9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W. Saratoga

19 (a) Nov 5 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-4-1948, at 11P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 4 1948 and that I last saw him alive on May 1 1948

Immediate cause of death: Cerebral Thrombosis — Duration 3 hrs.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Tilmanstetter Jr. M.D.
Address 1101 St. Paul St. Date signed Nov. 5, 48

VS 150

G68318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68318

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Broadway

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days (9 days)

(e) Length of stay in Baltimore (yrs., mos., or days) (9 days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Fla. (b) County Lake

(c) City or town Mount Dora (If outside city or town limits, write RURAL and give town)

(d) Street No. Box 93 (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Frederic Burston (Frederic Jewell Burston)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth W. Burston

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) Aug 19 71

8. AGE: Years	Months	Days	If less than one day
77	2	17	hr. min.

9. Birthplace Va. Falls Church (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

FATHER

12. Name Charles Hall Burston

13. Birthplace N.Y.

MOTHER

14. Maiden Name Sarah Jewell

15. Birthplace Vermont

16 (a) Informant Mr. F. Dawson Burston (son)

(b) Address JOHNS HOPKINS HOSPITAL 103-20-39th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 8 48 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Avenue

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 NOV. 1948 at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Oct 1948 to 4 NOV. 1948, and that I last saw him alive on 4 NOV. 1948.

Immediate cause of death (a) pulm. embolism — Duration 5 min

Due to (b) anemia + TVR — 9 days

Due to (c) lower nephron nephrosis

Other Conditions ASCVD

(Include pregnancy within 3 months of death)

Date of operation Oct 28 48

Major findings of operation: GSP

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wilfred E. Grotton

Address YHH Date signed 4 NOV. 48 (M. D.)

VS 150

G68319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

118

Registered No. G68319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philippine Weber

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hugo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12. 1871

8. AGE: Years 76 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Christian Jung
13. Birthplace Germany

MOTHER 14. Maiden Name Philippine Weber
15. Birthplace Germany

16 (a) Informant Mrs L Le Barry Jr
(b) Address 213 N Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore MD
Location Baltimore MD

18 (a) Funeral director Wilson & Lyne
(b) Address 1217 E Fort Ave

19 (a) NOV 6 - 1948 (Date received by registrar) Huntington Williams, MD (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4, 1948 19 . at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 11/4 1948. and that I last saw h alive on 11/4 1948.

Immediate cause of death Gastric Hemorrhage — Duration

Due to Hypertrophic Gastritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 29 1948

Major findings of operation: Bleeding from Hypertrophic Gastritis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen I. Moore M.D.
Address Sinai Hosp Dr Date signed 11-5-48

VS 150

668320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

668320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 1907
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB R. SATCHELL

3 (b) If veteran, name war: War II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Delina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1914

8. AGE: Years (smt) 34 | Months 1 2 | Days 16 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation G.I. School

11. Industry or business Tailor

FATHER
12. Name Cabel J. Satchell
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachel Bryant
15. Birthplace N. C.

16 (a) Informant: Harry Frink
(b) Address 7 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-48 (month) (day) (year)
(c) Cemetery or crematory Richmond. Va
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Hoffman St

19 NOV 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948, at 4:05 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema
d/t acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 11/4/48

VS 151

68321

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 68321

CERTIFICATE OF DEATH

181

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4212 Parkmont Ave.

(c) Hospital or institution: Parkmont Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)

(d) Street No. R.F.D.No 5 Bx 159 Dogwood Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME AMOS E, TRIPLETT

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Annie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.4,1854

8. AGE: Years	Months	Days	If less than one day
93	11	1	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Ebinezer Triplett

13. Birthplace Baltimore Co., Md.

MOTHER

14. Maiden Name (Unknown) Lowe

15 Birthplace England

16 (a) Informant Mrs Michal Sullivan

(b) Address RFD 5 Box 159 Dogwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson, Md.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) NOV 6 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to 1948, and that I last saw him alive on Nov. 4 1948.

Immediate cause of death	Duration
Bronchio Pneumonia	
Following	
Burn of face	
week on Nov. 1, 1948	
Due to Senility	
Due to Carcinoma of face.	
Other Conditions Arteriosclerotic	

(Include pregnancy within three months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation:

Thomas J. Mackie M.D.

of autopsy: CHIEF OR ASST. MEDICAL EXAMINER.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 36/1

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence November 1, 1948 at ? M

(c) Where did injury occur? 4212 Parkmont Avenue (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Nursing Home (Specify type of place) While at work? No

(e) Means of injury While smoking pipe -- bandages on face caught fire

23. Signature T B Stevens M.D.

Address 3400 Edmondson Date signed 11/5/48

VS 150

G68322 ✗ ✓ G68322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Date similar (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Beaumont Ave #28 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON HENRY WALLACE

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-5150

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Gertrude E. Wallace
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) December 27, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	7	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Freight Agent
11. Industry or business Western Md. R. R.

FATHER
12. Name Joseph Wallace
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Shaffer
15. Birthplace Germany

16 (a) Informant Gertrude E. Wallace
(b) Address 107 Beaumont Ave. #28

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1948, at 8 37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1948, to 11/4 1948, and that I last saw h[illegible] alive on 11/4 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Uremia	5 days
Due to Chronic Glomerulonephritis	8
Other Conditions Hypertension (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Md. Gen. Hosp. Date signed 11/5/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

668323 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave. Balt. 7
(c) Hospital or institution: Virginia Lewis Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Braddish Ave. F
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) D
If yes, name country

3 (a) FULL NAME HARRY PRIESTERJAHN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 25, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Retired Silversmith
11. Industry or business S. Kirk & Son

FATHER
12. Name Charles A. Priesterjahn
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Wolff
15. Birthplace Germany

16 (a) Informant Miss Bertha Priesterjahn, sister
(b) Address 1507 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1948, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 21 1948 to November 5 1948, and that I last saw him alive on Nov 3 1948.

Immediate cause of death Arteriosclerotic cardiovascular disease — Duration 10 years

Due to

Due to

Other Conditions Hypertensive cardiovascular disease — 5 years
(Include pregnancy within 3 months of death)

Date of operation Sept 1948

Major findings of operation: Benign prostatic hypertrophy. Bilateral Inguinal hernea

If autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Traband M.D.
Address 3400 Wardlaw Ave, Balt. 7 Date signed 11/5/48

668324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. 668324

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St
(c) Hospital or institution: Maryland Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/5
(e) Length of stay in Baltimore (yrs., mos., or days) 72 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie May Dale
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 5, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	3	0		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business —

FATHER
12. Name Robert Dale
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margret Miller
15. Birthplace Baltimore

16 (a) Informant Rev. Stanley E. Cusick
(b) Address Westminster, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948, at 5:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4- 1948 to 11-5 1948 and that I last saw her alive on 11-5 1948

Immediate cause of death	Duration
Acute Hemorrhagic Gangrenous Cystitis	Week
Due to Papilloma of Bladder	Months
Due to	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: 11-5-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. C. Friday M. D.
Address Md. Genl Hosp. Date signed 11-5-48

VS 180

68525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

XJ 170C

Registered No. G68525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belcamp (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEPOT MULLER (LEO MILLER)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Muller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1912

8. AGE: Years	Months	Days	If less than one day
36	5	28	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name Lajos Muller
13. Birthplace Hungary

MOTHER
14. Maiden Name Illona Vorst
15. Birthplace Hungary

16 (a) Informant Mary Muller
(b) Address Belcamp, Maryland

17 (a) Interment, (b) Date thereof Nov. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Charles P. Nagel
Location 352 E. 67 St New York City

18 (a) Funeral director Howard K. McCubbin & Son
(b) Address Aberdeen Maryland

19 (Date rec'd by registrar) NOV 6 - 1948 Huntington Mitchell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 3:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-4-48 at 3:15 P M?
(b) Where did injury occur? 500' E. of Chesapeake Ave. nr. Phila. Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury auto into culvert

23. Signature Earle Rogers M.D. Medical Examiner.
Date signed November 5, 1948

VS 151

668326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

668326 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 N. Fulton Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Rev.) John Hendrick Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1861

8. AGE: Years 67 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace Jackson, Miss. (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name John Hendrick Johnson
13. Birthplace Jackson, Miss.

MOTHER
14. Maiden Name Hattie ? ?
15. Birthplace Jackson, Miss.

16 (a) Informant Mrs. Sarah F. Johnson
(b) Address 1535 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 1941 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Clarke
(b) Address 1691 Druid Hill Ave.

19 NOV 6 1941 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1941 at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1941 to Nov 4 1941, and that I last saw h[illegible] alive on Nov 2 1941.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	1 day
(b) Arteriosclerosis	17 days
Due to (c) Myocarditis	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3426 Bank St. Date signed 11/6/41

668327

48-12327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 19

668327
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 E. Chase St
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fe

5. Color or race h

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-48

8. AGE: Years | Months | Days | If less than one day 9 hr. 30 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R. Hite
13. Birthplace Balto. Victoria Va

MOTHER
14. Maiden Name Louise Gentry
15. Birthplace Roxboro N.C.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Returned by hospital

18 (a) Funeral director Atlantic Funeral Home

(b) Address

19 NOV 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-48 19 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Congenital atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1 Division St (Date signed)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 668328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N Hilton ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EURA E. HOLBROOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~Wife~~ William B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 11, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	22	min.

9. Birthplace Baltimore (Town, county, state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George T. Shealey
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Wm. B. Holbrook
(b) Address 802 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) NOV 6 1948 (Date received by Registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1928 to Nov 3 1948
and that I last saw h~~er~~ alive on Nov 3 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs.
Due to Hypertension (Arterial)	20 yrs
Due to Chronic Nephritis	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Tally M.D.
Address 351 Edmondson Ave. Date signed Nov 5 1948

VS 150

68329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 83a

Registered No. 68329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gatow & Wilkins
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Arbutus Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Lang -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	widowed

6 (b) Name of husband or wife Nicholas T. Lang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-7-65

8. AGE: Years	Months	Days	If less than one day
83	7	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation President
11. Industry or business Aseptinol Mfg. Co.

FATHER
12. Name James Welslager
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Harken
15. Birthplace Md.

16 (a) Informant William C. Rogers
(b) Address 1525 Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director John B. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place, Huntington Avenue, Md.

19 (a) NOV 6 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/ 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov-2 1948 to Nov 5 1948, and that I last saw h alive on 19

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to CEREBRAL VASCULAR ACCIDENT

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Shaw M. D.
Address St. Agnes Hosp. Date signed 11/6/48

VS 150

X

68330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 68330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 E. Madison St.
(c) Hospital or institution: 7-0

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS PAUL MEYER, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida Brodt Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	19	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Mrs. Ida Brodt Meyer
(b) Address 2419 E. Madison St.

17 (a) Burial (b) Date thereof 11/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & [illegible]ay St.

18 (a) Funeral director Schimmel[illegible] Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

19 NOV 6 - 1948 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to inhalation of illuminating gas.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 4/48, approx. 9 A.M.
(b) Where did injury occur? 2419 E. Madison St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 3 burners on but unlit

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/4/48

VS 151

668331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 668331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Ridgecroft Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Ridgecroft Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward I. Radecke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha (nee Gosper)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 2, 1902

8. AGE: Years	Months	Days	If less than one day
46	-	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Boston Metal Company

FATHER
12. Name Jacob Radecke
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hyjak
15 Birthplace Germany

16 (a) Informant Mrs. Bertha Radecke
(b) Address 4000 Ridgecroft Road

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 6 - 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 1215 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1948 to 11/4 1948 and that I last saw h— alive on 11/3 1948.

Immediate cause of death: Carcinoma of the Colon — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel L. Gross M. D.
Address 1769 E. Monument signed 11/5/48

VS 150

668332 Picozzi

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 668332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Castle St (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Mrs. Mary D.C. Picozzi

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-7116

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Carlo Picozzi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-92

8. AGE: Years	Months	Days	If less than one day
56	10	4	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace Italy

MOTHER
14. Maiden Name —
15. Birthplace Italy

16 (a) Informant Carlo Picozzi
(b) Address 608 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 6 - 1948 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-48 19 . at 1.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948. to 11-4 1948.
and that I last saw h.r. alive on 11-4 19 48

Immediate cause of death	Duration
Cardiac Arrest	Instant
Due to Cerebrovascular Accident	
Due to Arteriosclerosis, Gen'l.	
Other Conditions Diabetes mellitus	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Rosen, Jr. M. D.
Address Mercy Hosp Date signed 11-7-48

VS 150

668333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 668333

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 842 Mangold St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Preuhe (Preubis)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2465

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name Semas Preubis

13. Birthplace Luth

MOTHER

14. Maiden Name

15. Birthplace Luth

16 (a) Informant Bertha Preubis

(b) Address 842 Mangold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd

18 (a) Funeral director Joseph Lauinkas Sr

(b) Address 40 Washington Blvd

19 (d) NOV 6 - 1948 (Date rec'd by registrar) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1948 at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1948 to 11-4 1948, and that I last saw h in alive on 11-4 1948.

Immediate cause of death Intracerebral hemorrhage — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature R. E. Evans M.D.

M. D.

Address University Hosp. Date signed 11-5-48

VS 150

68334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 68334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341 Mosher St.
(c) Hospital or institution:
flor

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence D. Caldwell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Mamie Caldwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1897

8. AGE: Years	Months	Days	If less than one day
51	10	~ 24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Caldwell
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Waters
15. Birthplace Toronto, Canada.

16 (a) Informant Ethel Morrison.
(b) Address 1341 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by reg.) NOV 8 1948 (b) Huntington (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948, at 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Nov 3 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death: Coronary occlusion — Duration: Unkn

Due to

Due to

Other Conditions Aortic Insufficiency Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Ghrist M.D.
Address 902 W. Franklin Date signed 11-5-48

G68335 ✓ G68335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

CH. 124275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 Holland Ave. (If rural give location)
(e) Citizen of foreign country? Harlem (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Arthur Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	10	3	hr. min.

9. Birthplace ? Newport News, Va.,
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Henry Coy
13. Birthplace Newport News, Va.

MOTHER
14. Maiden Name ? Mary
15. Birthplace Newport News, Va.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof Nov 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Farmingdale
Location National Cemetery N. Y.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) NOV 6 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 4 - 19 48 at 2.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 3- 19 48 to 11- 4- 19 48 and that I last saw her alive on 11- 4 - 19 48.

Immediate cause of death Sub-arachnoid hemorrhage-ruptured into ventricles — Duration Hrs

Due to aneurysm ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Nelson M. D.
Address BCH Date signed 11-4

VS 150

G68336
B-124281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 82a

Registered No. G68336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Midway zone 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Vernon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 15-1899

8. AGE: Years	Months	Days	If less than one day
48	11	20	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Harry J ?Tully
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mrs. Gracey
15. Birthplace Pennsylvania

16 (a) Informant Records - Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) ~~Cremation~~ Burial (b) Date thereof Nov 9-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 1[illegible] Mt Royal Ave

19 (a) NOV 6 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5- 1948, at 5.15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-3- 1948, to 11-5- 1948, and that I last saw h[illegible] er alive on 11-5- 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 48 hrs
Due to Essential hypertension — 12 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Beckstead M. D.
Address Balto City Hosp. Date signed 11-6-48

VS 150

X

668337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

Registered No. 668337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 19-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL FRANK HARMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-2334

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Elsie H. Harman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 2, 1900

8. AGE: Years	Months	Days	If less than one day
48	9 2	26 3	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Railroader

FATHER
12. Name Chas. H. Harman
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Carrie Wilhide
15. Birthplace Carroll Co., Md.

16 (a) Informant F. A. Sharrer
(b) Address Westminister, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Westiminister, Md.

18 (a) Funeral director F. A. Sharrer
(b) Address Westminister, Md.

19 (a) NOV 6 - 1948 (Date rec'd by registrar) (b) Thurlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place or public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D. (Medical Examiner)
Date signed 11/5/48

VS 151

668338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 128

668338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1946 Sponson Street
(c) Hospital or institution: 25 c2
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 Sponson Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN NORATEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-3165

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EVA B. NORATEL
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) Sept- 28 -1885

8. AGE: Years	Months	Days	If less than one day
63	1	5	***hr. ***min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Noratel
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslavakia

16 (a) Informant (Wife) Mrs. Eva B. Noratel
(b) Address 1946 Sponson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

19 (a) [redacted] Date rec'd [redacted] Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948 at 4:30A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8 1948 to 19 48 and that I last saw him alive on Nov 1 1948

Immediate cause of death Tuberculosis of Lungs & Kidneys.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosenberg M.D.
Address 2411 WASHINGTON BLVD. Date signed 11/ /48

NOV 6 [redacted]

VS 150

Dr. C. Arthur Rosenberg

6839 # 7 # 36

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 737

Registered No. 668539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Paul~~ Pappas - Nicholas Christ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-10-38

8. AGE: Years	Months	Days	If less than one day
10	5	25	hrs. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name Christophe - Pappas
13. Birthplace Greece
14. Maiden Name Cilly Laccas
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6-48 (month) (day) (year)
(c) Cemetery or crematory Greek -
Location Woodmere Md.

18 (a) Funeral director Symbras - Funeral Home Inc
(b) Address 440 East North Ave. Baltimore, Md

19 (a) NOV 6 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-1948 at 1:43 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-1948 to 11-4-1948 and that I last saw him alive on 11-4-1948

Immediate cause of death: Anaemia — Duration

Due to: Erythroblastic anaemia (Cooley's)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Fang M. D.
Address John's Hopkins Hosp Date signed 11-4-48

VS 15)

68340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3133 Virginia Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 - 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3133 Virginia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Ochs.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth C. Ochs

6 (c) If alive, give age yedrs

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired Interior Decorator,
11. Industry or business

FATHER
12. Name Adam Ochs.
13. Birthplace Germany,

MOTHER
14. Maiden Name unknown
15. Birthplace Germany,

16 (a) Informant Mrs. Elizabeth C. Ochs.
(b) Address 3133 Virginia Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Coleman Lemmon
(b) Address 4611 Park Heights Ave.,

NOV 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948 at 8.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1948 to 11/4 1948 and that I last saw him alive on 11/4 1948.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 10/20/48

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Bechtold M. D.
Address 4803 Park Heights Date signed

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68341 | BALTIMORE CITY HEALTH DEPARTMENT | 68341
Registered No.

CERTIFICATE OF DEATH

95 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York
(c) City or town Delta (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Grafton Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 7 1891

8. AGE: Years	Months	Days	If less than one day
56	10	30	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Delmar Thompson
13. Birthplace Penna

MOTHER
14. Maiden Name Elizabeth Ramsey
15. Birthplace Penna

16 (a) Informant Edwin Thompson
(b) Address Delta, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location York Co. Pa.

18 (a) Funeral director Hubert P. Jenkins
(b) Address Delta, Pa.

19 (a) Date received by local registrar Nov 9 1948 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1948, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1948, to Nov 6 1948, and that I last saw him alive on Nov. 6 1948.

Immediate cause of death Pulmonary embolism — Duration

Due to Pneumonia

Due to Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Smith Jr M. D.

Address Date signed

668342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

668342 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Smallwood St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Wiedmaier, Bernhard. (Bernhard Wiedmaier)
3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Rosa L. Wiedmaier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 24, 1884

8. AGE: Years 64 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tavern keeper
11. Industry or business Self.

FATHER
12. Name Christian Wiedmaier
13. Birthplace Germany

MOTHER
14. Maiden Name Magdelena Egner
15. Birthplace Germany

16 (a) Informant Rosa Louisa Wiedmaier
(b) Address 11 S. Smallwood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George F. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 7 - 1948 (b) (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948, at 8 10 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-5 1948 to 11-5 1948, and that I last saw him alive on Nov 5 1948.

Immediate cause of death: Pulmonary edema & congestive Ht. failure
Due to: arteriosclerosis, diabetes, cirrhosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. J. Finkell M. D.
Address Franklin Sq. Hosp. Date signed 11-5-48

VS 150

X

G68343 ✓ X G68343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same
(a) State Md (b) County a e
(c) City or town Bad Gate
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) **FULL NAME** Benjamin 6 Britton (Brittain) Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose Eva Brittain

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1893

8. **AGE:** Years 55 | Months 9 7 | Days 11 | If less than one day hr. min.

9. Birthplace Eastport Maryland
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name George H Brittain
13. Birthplace Eastport Md

MOTHER
14. Maiden Name Elizabeth Colburn
15. Birthplace Annapolis Md

16 (a) Informant Rose Eva Britton
(b) Address Annapolis Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 48 (month) (day) (year)
(c) Cemetery or crematory Locust Knoll
Location Annapolis Md

18 (a) Funeral director H H Hopkins & Son
(b) Address Annapolis Md

19 NOV 7 1948 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 6 1948 at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 28 48 19 to 11 6 19 48.
and that I last saw him alive on 11 6 19 48.

Immediate cause of death Cardiac Arrest — Duration

Due to Coronary Thrombosis

Due to Carcinoma of Rectum Postoperative

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10 28 48

Major findings of operation: Carcinoma Rectum

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H C Clampett M. D.
Address University Hospital Date signed 11 6 48

Baltimore 2, MD X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G68344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 Hudson st.
(c) Hospital or institution: 1-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Hudson st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ekielski

3 (b) If veteran, name war

3 (c) Social Security Account No 216-03-2346

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Bertha Ekielski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5/1877

8. AGE: Years	Months	Days	If less than one day
71	8	-	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Stenenowicz Bro

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Bertha Ekielski
(b) Address 3040 Hudson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill road

18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1000 S. Kenwood ave

19 (a) NOV 7 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948 at 2:55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948, to Nov 5 1948, and that I last saw h alive on Nov 5 1948.

Immediate cause of death	Duration
Chr. hypocondritis	11-2-48
Livir Cirrhosis	11-2-48
Due to Acute Coronary Occlusion	11-5-48
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eli Schimunek M. D.
Address 84 2nd Ea Mel Date signed 11-5-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G68345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-21-86

8. AGE: Years	Months	Days	If less than one day
62	1	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jessie Ford
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Starling
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location Baltimore Md

18 (a) Funeral director Chas O. Wilson
(b) Address 6000 Belmont ave

NOV 1 - 1948 (b)
(Date rec'd by Registrar) Washington Williams, M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 10.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1948 to 11-4 1948, and that I last saw him alive on 11-4 1948.

Immediate cause of death: Acute pulmonary edema
Due to: Coronary insufficiency
Due to: ARTERIOSCLEROSIS
Other Conditions: Multiple contractures

Duration: 2 hours / many years / 6 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: see above.
Was autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Talbot M. D.
Address J. H. Hosp. Date signed 11/5/48

VS 150

G68346 ✓ G68346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 605
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BISHOP HILL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1929 or 23

8. AGE: Years	Months	Days	If less than one day
26	8	21	hr. min.

9. Birthplace Jayeso, Miss. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Thomas Harding
(b) Address 1633 E. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cemetery
Location Balto., Md.

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Bloomfield ave

19 NOV 7 - 1948 (Date rec'd by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948 at 11:56 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab-wound of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-48 at 11:30 P. M.
(b) Where did injury occur? Fayette & Dallas St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D. (Medical Examiner.)
Date signed 10-30-48

X

G68347 Rugland ✓ G68347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-01
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Eden St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George Rugland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Helen Miller
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-2-70

8. AGE: Years	Months	Days	If less than one day
78	9	-	hr. ..... min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

MOTHER | FATHER
12. Name Perry Rugland
13. Birthplace Ala.

MOTHER
14. Maiden Name Frances Threet
15. Birthplace Ala.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bloxtty ave

19 (a) Nov 9 1948 (Date rec'd by registrar) (b) .....
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948, at 8 25 P M

21. I certify that death occurred on the date above stated: that I attended deceased from 9-22 1948, to 11-2 1948, and that I last saw him alive on 11-2 1948.

Immediate cause of death	Duration
Cachexia	
Due to Carcinomatosis	
Due to Carcinoma of colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/2/48
Major findings of operation: Carcinoma of colon
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Richard F. Ruffin, Jr. M.D.
Address Johns Hopkins Hosp. Date signed 11/2/48

G68348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68348 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N. Caehorn St.
(c) Hospital or institution: 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Caehorn St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country British West Indies

3 (a) FULL NAME Henry John Landsdowne / LANSDOWNE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Roslyn Landsdowne LANSDOWNE
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan. 9 1881

8. AGE: Years 67 | Months 9 | Days 26 | If less than one day: hr. min.

9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business B & O Shop

FATHER
12. Name David Landsdown LANSDOWNE
13. Birthplace B. Md.

MOTHER
14. Maiden Name Longsworth
15. Birthplace B. Md.

16 (a) Informant Mrs Vera L. Gray
(b) Address 1816 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 7-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Parks
Location Arbutus Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Blandford Ave

19 (a) NOV 7 - 1948 (b) (Date rec'd by registrar) Certificate for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 4 - 1948 at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26-1948 to 11-4-1948, and that I last saw him alive on 11-3-1948

Immediate cause of death: Bronchopneumonia — Duration: 39 days
Due to
Due to
Other Conditions Carcinoma Hemorrhage — 1 year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 11-4-48

VS 158

107

668349

BALTIMORE CITY HEALTH DEPARTMENT ✓

668349

Registered No.

CERTIFICATE OF DEATH 181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna Farmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 19, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	14	17 hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation school teacher

11. Industry or business

FATHER
12. Name Joseph L. Farmer
13. Birthplace Baltimore Co. Md

MOTHER
14. Maiden Name Mary Adams
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Charles E. Farmer
(b) Address 2905 N. Charles St.

17 (a) Burial (b) Date thereof 11/8/48.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Moran, John A.
Address 4201 York Rd.

19 (a) (b)
(Date rec'd by reg.) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1948. to 11-5 1948.
and that I last saw her alive on 11-5 1948.

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Hypertn. Renal Insufficiency	
Due to Overwhelming Uremia	
Other Conditions Hypertensive Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY PHYSICIAN

Major findings of operation:

for C. J. Jirmski M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-5-48 at 3:05 P M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury Fell in tub of boiling water

23. Signature Charles E. Carter Jr. M. D.
Address St Agnes Hosp. Date signed 11-5-48
for Baltimore City Medical Examiner

VS 150

G68350 ✓ G68350

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Wolfe St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Lindsay Worthy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife Jessie Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1888

8. AGE: Years	Months	Days	If less than one day
59 160	10	18	hr. min.

9. Birthplace York County S. C. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sam Meeks
13. Birthplace S. C.

MOTHER
14. Maiden Name Jane Thompson
15. Birthplace S. C.

16 (a) Informant Bessie Stewart
(b) Address 814 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.
Location Balto. County

18 (a) Funeral director Mrs. Pitt. Allen & Son
(b) Address 1129 N. Carolina St.

19 (a) [illegible] (Date rec'd) (Registrar) Huntington Williams M.D. Registrar

NOV 7 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-1948 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31/48 to 11-4-1948. and that I last saw [illegible] alive on 11-4-1948.

Immediate cause of death (a) Pulmonary tuberculosis — Duration 2 yrs 6 mos

Due to (b) Cardio-renal. — 12 mos

Due to (c) Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature W. W. Hall, M.D.
Address 1603 N. Carolina St. Date signed 11/4/48

G68351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

G68351
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miles Sherill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Jennie

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1878

8. AGE: Years	Months	Days	If less than one day
70	-	20	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Dan Sherill
13. Birthplace S. C.

MOTHER
14. Maiden Name Margaret?
15. Birthplace S C

16 (a) Informant Jennie Sherill
(b) Address 518 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County Md.

18 (a) Funeral director Mrs. M. A. Elbert & Son
(b) Address 1029 N. Carlton St.

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 48, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1948, to 11-4- 1948, and that I last saw him alive on 11-4- 1948.

Immediate cause of death Myocarditis
Due to Arterio Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 6 mos 9 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature H V Kuhl M.D.
Address 503 N. Carolina Date signed 11/4/48

668352 668352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lenai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Melno Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maurice J. Goodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife Jean | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years (55) 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Liquor business

11. Industry or business

FATHER 12. Name Henry
13. Birthplace Russia

MOTHER 14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Jean Goodman
(b) Address 3705 Melno Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place

19 (a) Date received by registrar NOV 7 - 1948 (b) Registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948 at 7:20 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-6 1948 to 11-6 1948, and that I last saw him alive on 11-6 1948.

Immediate cause of death: Ca of lung & metastases — Duration:

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca of lung & metastases

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Strauss M. D.
Address Sinai Hosp. Balt Date signed 11-6-48

668353

BALTIMORE CITY HEALTH DEPARTMENT ✓ 668353 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1140 Warner St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Sandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-91

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name Manuel
13. Birthplace Russia

MOTHER 14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Lena Sandler
(b) Address 1140 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Filed 11-7-1948 (b) Received by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 6 1948. and that I last saw him alive on Nov. 6 1948.

Immediate cause of death: Complete coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadan M. D.
Address 2306 Eutaw Pl Date signed 11-6-48

VS 150

X

668354 668354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Warwick Ave
(c) Hospital or institution: 15-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Warwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Goldie Abramovitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Molge
15. Birthplace Russia

16 (a) Informant Henry Abramovitz
(b) Address 1803 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Place

19 (a) NOV 7 - 1948 (Date rec'd by registrar) (b) Huntington & William Sts

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 - 1948 at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 6 1948 to 11/7 1948 and that I last saw h-r alive on 11/6/1948

Immediate cause of death: Coronary Thrombosis — Duration: 15 min

Due to: Hypertensive Cardio-Vascular Disease — Duration: ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 N. North Ave Date signed 11/7/48 M. D.

VS 150

G68355 ✓ G68355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns
(c) Hospital or institution: Hosp. Women Maryland 07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Apts - 11
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Ammidon (ESTELLE-JOSEPHINE-HOYT-AMMIDON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	W. Divorced

6 (b) Name of husband ~~or wife~~ Daniel G Ammidon
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept - 23 - 1876

8. AGE: Years	Months	Days	If less than one day
72	1	14	hr. min.

9. Birthplace Stanford - Conn.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name George Hoyt
13. Birthplace Stanford - Conn

MOTHER
14. Maiden Name Josephine Bailey
15. Birthplace ? - Conn.

16 (a) Informant Estelle Ammidon (Self)
(b) Address Wyman Apts - Balto - 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Stamford Conn

18 (a) Funeral director Shivers Morris Co.
108 W Mt Ave

19 (a) [illegible] Washington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 6 - 1948, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 16 1948 to Nov 6 1948, and that I last saw her alive on Nov - 6 - 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Intestinal obstruction	
Due to Carcinoma of Uterus	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George G. Gaskins M. D.
Address Hosp. Women Md. Date signed 11-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G68356 ✓ G68356

JL - 121502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 13 08
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 W. 36th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mandy Crawford

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ? 1865

8. AGE: Years	Months	Days	If less than one day
83 ?	7		hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Duffield
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Dulaney
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director Paul E. Shannon Thos
(b) Address 3615-12 Chestnut Ave

19 (a) NOV 9 - 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1948 to Nov. 5 1948, and that I last saw her alive on Nov. 5 1948.

Immediate cause of death	Duration
Carcinometosis	
Due to Carcinoma of bladder	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/27/48 (Cystoscopy)
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. P. Novinsky M. D.
Address Balto City Hosp Date signed 11/6/48

VS 150

X

G68357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

G68357
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Grindale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Lenhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-7488

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Hung
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 25 1889

8. AGE: Years	Months	Days	If less than one day
59	9	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Southern Hotel

FATHER
12. Name Charles Long
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John Long
(b) Address 117 N. Elwood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md

18 (a) Funeral director Uffelfinger Funeral Home
(b) Address 2006 Orleans St.

19 (a) 11/7/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948 at 1:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948 to 11-5 1948, and that I last saw her alive on 11-5 1948.

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Hypertensive Cardiovascular disease	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome Gaber M.D.
Address Sinai Hosp Date signed 11-5-48

G68358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G68358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 Woodward St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Woodward St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Albert Clayton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1878

8. AGE: Years 70 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace York Md.
(Town, county, and state)

10. Usual Occupation Car repairman

11. Industry or business B & O R.R. Co

FATHER
12. Name Jesse Clayton
13. Birthplace York Md

MOTHER
14. Maiden Name Beards
15. Birthplace York Md

16 (a) Informant John F. Clayton
(b) Address 795 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory York M.E. Church
Location York Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Eastern Ave Baltimore, Md

19 (a) Nov 9 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948 at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7th 1948 to Nov 5 1948 and that I last saw h-- alive on Nov 5th 1948.

Immediate cause of death — Duration
Myocarditis — 7 years
Due to
Due to Arteriosclerosis — 9 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Was autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Clayton
Address 517 Scott St. Date signed 11/6/48.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

G68359
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 S. Fulton ave
(c) Hospital or institution: 1904

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Fulton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nelson Hoffman Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella Young Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12-1892

8. AGE: Years	Months	Days	If less than one day
56	1	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Shoe Maker

11. Industry or business Foundry

FATHER
12. Name Thomas B. Hoffman
13. Birthplace Md

MOTHER
14. Maiden Name Emma B. Harrison
15. Birthplace Md

16 (a) Informant Mrs. Ella Y. Hoffman
(b) Address 513 S. Fulton ave

17 (a) Burial (b) Date thereof 11-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Bell Jr
(b) Address 1512 Hollins St.

19 (a) [illegible] Washington Williams Asst. Registrar
(Date rec'd by Registrar) NOV 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4- 1948, at 6 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21- 1946 to Nov 4 1948, and that I last saw him alive on Nov 4- 1948.

Immediate cause of death	Duration
Carcinomata of Lungs	
Due to Uncertain.	
Due to	
Other Conditions, Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Fletcher M. D.
Address 2151 Wilkens Date signed 11/3/48

XS

68360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 668360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution: 15-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Denison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma V. Micou

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1850

8. AGE: Years 97 | Months 10 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Micou
13. Birthplace Va.

MOTHER
14. Maiden Name Ann, Rawlings
15. Birthplace Md.

16 (a) Informant Mrs. Emma A. Campbell
(b) Address 4608 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) NOV 3 1948 (Registered by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/ 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1948 to Nov. 6 1948, and that I last saw her alive on Nov. 6 1948.

	Duration
Immediate cause of death Cardio-Pulmonary Disease	3-4 yrs.
Due to Cerebral Arteriosclerosis Uremia	
Due to	
Other Condition Terminal Edema of Lungs (Include pregnancy within 3 months of death)	8-10 hrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry A. Bobey M. D.
Address 2504 St Paul St. Date signed 11/7/48

VS 150

Cancer age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town East Prospect (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold Kline
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Phylis
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr) 9-26-06
8. AGE: Years 42 | Months 1 | Days 11 | If less than one day: hr. min. 10
9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Stone Quarry
11. Industry or business

MOTHER / FATHER
12. Name George Kline
13. Birthplace Pa
14. Maiden Name Ida Harris
15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)
(c) Cemetery or crematory East Prospect
Location Lower Windsor, Pa.
16 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md.

NOV 8 1948 (Date rec'd by registrar)
(b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 3:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1948 to 11/6 1948.
and that I last saw h alive on 11/4 1948.
Immediate cause of death (1) Terminal uremia, secondary to (2).
Due to (2) Probable Kimmelstiel-Wilson syndrome
Due to Diabetes mellitus
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: over 4

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman E Thaeler M. D.
Address Johns Hopkins Hospital Date signed 11-7-48

VS 150

68362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 68362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 Abbott Court
(c) Hospital or institution: 10-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Lerner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna B. Lerner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1869

8. AGE: Years 79 | Months 4 | Days 20 | If less than one day: hr. min. 19

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Elsa Spitz
(b) Address 2228 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1948 to Nov 4 1948. and that I last saw him alive on Nov 2 1948

Immediate cause of death	Duration
Coronary Occlusion,	1 day
Due to	
Due to Auricular Fibrillation	11 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2201 E Madison St Date signed 11/5/48

VS 150

G68363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G68363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Allendale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1890

8. AGE: Years	Months	Days	If less than one day
58	4	4	hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER
12. Name Littleton P. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Florence L. Harry
15. Birthplace Va

16 (a) Informant Mr Stuart L. Brown,
(b) Address Upper Marlboro, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn, 11/9/48
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 8 - 1948 (Date rec'd by registrar) (Huntington for Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948, at 5:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948, to 11-6 1948, and that I last saw him alive on 11-6 1948.

Immediate cause of death Respiratory failure

Due to pneumonia

Due to congestive Heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. J. Finkell M. D.
Address Franklin Sq. Hospit Date signed 11-6-48

VS 153

668364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

668364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 E. Madison St.
(c) Hospital or institution: J-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GUSTAV KOEHLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 15, 1875

8. AGE: Years	Months	Days	If less than one day
73	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cabinet Maker Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15 Birthplace "

16 (a) Informant Mrs Jane Jenkins
(b) Address 1918 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 8 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 5 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1948 to 11/4 1948, and that I last saw him alive on 11/4 1948.

Immediate cause of death: (a) Myocarditis — Duration

Due to: Carcinoma of lung

Due to: " " prostate

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 4/48

Major findings of operation: Carcinoma of prostate

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Hommeter M.D.
Address 1042 Bradley Blvd Date signed 11/6/48

VS 150

68365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

668365
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Montpelier St.
(c) Hospital or institution: U of M

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES A. G, LEONARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	216-03-9846

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name Paul Leonard
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret Melzger
15 Birthplace Unknown

16 (a) Informant Robert J. Leonard
(b) Address 934 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 5 1948, and that I last saw him alive on Nov. 4 1948.

Immediate cause of death: Carcinoma of Descending Colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Oct. 1948
Major findings of operation: Carcinoma of Large Bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward B. Wolfe, M.D.
Address 1331 Chatsworth Date signed 11-6 1948

VS 150

68366 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 68366

CERTIFICATE OF DEATH 45F Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town Poplar Bluff (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Lindsey St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence William LAMEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth Lamey
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1907

8. AGE: Years	Months	Days	If less than one day
41	10	22	hr. min.

9. Birthplace Miss. (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Seafarer

FATHER
12. Name William Lamey
13. Birthplace Miss

MOTHER
14. Maiden Name Betty Hopkins
15. Birthplace Texas

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/7/48 (month) (day) (year)
(c) Cemetery or crematory Poplar Bluff
Location Missouri

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Nov 8 1948 (Date received) (b) Clifton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7, 1948, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Nov 7 1948, and that I last saw h. im alive on Nov. 7 1948.

Immediate cause of death: Carcinoma of left tonsil with extension to left neck — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. C. Robertson M. D.
W. C. Robertson
Address US Marine Hospital Date signed 11/7/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668367 WIRTH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

668367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address 3413 Guilford Terrace
(c) Hospital or institution: 12-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Guilford Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. B. (Mrs. Frank) Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1863

8. AGE: Years	Months	Days	If less than one day
85	2	22	hr. min

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name	(Unknown) (Frank) Baals
FATHER 13. Birthplace	Germany
MOTHER 14. Maiden Name	Marie Kuppert
MOTHER 15. Birthplace	Germany

16 (a) Informant Margaret B. Wirth
(b) Address 3413 Guilford Terrace

17. Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm & Long
(b) Address 1219 E. Fort Ave

19. NOV 8 1948 (b) Funeral Home, Baltimore, Md.
(Date rec'd by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Friedman M.D.
Medical Examiner.
Date signed 11/7/48

68368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 68368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4048 Hilton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4048 Hilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fern Sophia Fulverman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-4481

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1895

8. AGE: Years	Months	Days	If less than one day
53	8	1	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation
11. Industry or business Clerk

FATHER
12. Name Max Fulverman
13. Birthplace Poland

MOTHER
14. Maiden Name Bloma Klein
15. Birthplace Poland

16 (a) Informant Mr David M Klein
(b) Address 3407 Springdale Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Huntington W Va
Location W Va

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 8 1948 (b) Huntington Williams, M.D.
(Month, day, year) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948, at 12:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1946 to 11-6 1948, and that I last saw h alive on 11/6 1948

Immediate cause of death: Carcinoma of Breast — Duration: 18 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B Ford

Address 330 Eutaw St Date signed 11/6/48

VS 150

68369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 68369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 N. Mount Street
(c) Hospital or institution: 19-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Mc Dowan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Helen Mc Dowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1883

8. AGE: Years	Months	Days	If less than one day
65	-	4	hr. min.

9. Birthplace West River, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Helen Mc Dowan
(b) Address 103 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 8 - 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore County

18 (a) Funeral director Searage L.A. Gibbons
(b) Address 5 Druid Hill Ave.

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 2 - 1948 to 11 - 4 - 1948. and that I last saw h alive on 11 - 3 - 1948.

Immediate cause of death Uremic coma
Cirrhosis Liver

Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Jackson M. D.
Address 600 N. Arlington Ave. Date signed 11 - 6 - 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1062

G68370 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2838 Fairford Ave

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State N. J. (b) County

(c) City or town Hackettstown

(If outside city or town limits, write RURAL and give town)

(d) Street No. 77 Main St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Wallace Bates

3 (b) If veteran, name war Yes

3 (c) Social Security Account No. 137-34-3170

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife No

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-9-1918

8. AGE: Years	Months	Days	If less than one day
30	9	28	hr. min.

9. Birthplace Montpelier - Vermont.

(Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Steel

FATHER 12. Name Edward K. Bates

FATHER 13. Birthplace Vermont.

MOTHER 14. Maiden Name Harriet Scott

MOTHER 15. Birthplace Canada

16 (a) Informant

(b) Address

17 (a) Removal (b) Date thereof 11-8-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hackettstown Memorial Cemetery Location Hackettstown N. J.

18 (a) Funeral director Earl B. Robertson - Inc

(b) Address 407 E. 26th St.

19 NOV 8 - 1948 (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Nov 7 1948 and that I last saw him alive on Nov 7 1948.

Immediate cause of death	Duration
Acute congestion pulmonale	15 min
Due to Bronchial asthma Emphysema	25 yr.
Due to	
Other Conditions Bronchiectasis	10 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Norman R. Freeman M.D.

Address 11 W. 29th St Date signed Nov 8 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

112

68571 ✓ 68571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 1803
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Poppleton St. (If not definitive location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Philip A. McGraw

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sarah C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-31-83

8. AGE: Years 64 | Months 10 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation machinist Helper

11. Industry or business Retired

FATHER
12. Name Philip McGraw
13. Birthplace Balto MD.

MOTHER
14. Maiden Name Mary Madigan
15. Birthplace Ireland

16 (a) Informant Mrs. Sarah C. McGraw
(b) Address 425 Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Mayr Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) [illegible] (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 19 48 at 9 35/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 19 48 to 11-6 19 48.
and that I last saw him alive on 11-6 19 48.

Immediate cause of death: Cardiac failure — Duration:
Due to Chronic portal Cirrhosis
Due to Malnutrition Chronic Alcoholism
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature [signature]
Address Mercy Hospital Date signed 11-6-48 M. D.

VS 150

G68372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G68372

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland BRENDAN
(b) Street address 2803 Brandon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Brandon ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Andrew John Mc Cart

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, ~~divorced~~
M	W	Widowed

6 (b) Name of husband or wife Mary Mc Cart
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Feb 21-1879

8. AGE: Years	Months	Days	If less than one day
69	8	16	..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Not Known
13. Birthplace .....

MOTHER
14. Maiden Name Not Known
15. Birthplace .....

16 (a) Informant Mrs Edward Mayo
(b) Address 2803 Brandon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Hoey & Son
(b) Address 3001 Pentachy ave

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at ..... M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 10 1947, to Nov 5 1948
and that I last saw h alive on Nov 5 1948.

Immediate cause of death	Duration
Acute Heart failure.	
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature S B Stevens Col
Address 3400 Erdman Date signed 11/9/48

VS 154

668373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

668373 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 No Payson St
(c) Hospital or institution: 1504

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 No Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Sklar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Chasha
15. Birthplace Russia

16 (a) Informant David Sklar
(b) Address 1918 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Hilligoss, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1948 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 7 1948 and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death	Duration
Chronic hypertrophic Leukemia	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lashman M.D.
Address 1421 W Monte Ave Date signed 11/9/48

VS 150

68374 ✓ G68374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MONUMENT ST

(c) Hospital or institution: SINAI Hospt 3 01

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County .....

(c) City or town BALTO

(If outside city or town limits, write RURAL, and give town)

(d) Street No. TEMPLE Garden Apts 403 A

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Leon Schmastzman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SHEBY

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-2

8. AGE: Years	Months	Days	If less than one day
56			hr. ..... min.

9. Birthplace NEW ORLEANS (Town, county, and state)

10. Usual Occupation MFG

11. Industry or business

FATHER

12. Name HARRM

13. Birthplace NEW ORLEANS

MOTHER

14. Maiden Name MATHILDA

15. Birthplace NEW ORLEANS

16 (a) Informant WIFE

(b) Address .....

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)

(c) Cemetery or crematory ARLINGTON

Location ROGERS AVE

18 (a) Funeral director Jack Levin Inc

(b) Address 2100 Eutaw Place

19 NOV 8 - 1948 Washington Williams, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-1948 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1948 to 11-7-1948. and that I last saw him alive on 11-7-1948

Immediate cause of death	Duration
Acute myocardial infarction	
Due to Coronary sclerosis	
Due to Arteriosclerosis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature I. E. Hamm M. D.

Address Sinai Hospital Date signed 11-7-48

VS 150

X

G68375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68375

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 501-S. Pulaski St.

(c) Hospital or institution:

10-03

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 501-S. Pulaski St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. ROSS.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married.

6 (b) Name of husband or wife Estella L. Ross.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1869

8. AGE: Years	Months	Days	If less than one day
78	10	24	hr. min.

9. Birthplace Virginia.
(Town, county, and state)

10. Usual Occupation Former. (Retired)

11. Industry or business Arundel Corp.

FATHER
12. Name Charles E. Ross.
13. Birthplace New York.

MOTHER
14. Maiden Name Sarah Hatley.
15. Birthplace Virginia.

16 (a) Informant Miss Mary Calvert.
(b) Address 501-S. Pulaski St.

17 (a) Burial - (b) Date thereof Nov. 8-48.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Good Shepherd Cem.
Location Rossland, Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512-Frederick Ave.

19 (a) Filed Nov 8 - 1948 (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5- 1948. at 10.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1- 1948. to Nov. 5- 1948. and that I last saw h[illegible] alive on Nov. 5- 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert M. Gale M. D.

Address 2030 Walbrook Ave. Date signed 11-6-48

V S 150

668:576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

668:576
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lawrence St
(b) Street address 545 Lawrence St
(c) Hospital or institution: 14-0 V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Lawrence St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/12

8. AGE: Years	Months	Days	If less than one day
36	4	19	hr. min.

9. Birthplace Rocky Mt NC
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wm Simons
13. Birthplace NC

MOTHER
14. Maiden Name Arenia King
15. Birthplace NC

16 (a) Informant Wm Simons
(b) Address 1917 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 [illegible] by [illegible] Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/48 to 11/4/48 and that I last saw h[illegible] alive on 11/4/48.

Immediate cause of death: General Hardening (Duration)
Hypertensive

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Harrison MD
Address 1131 Harlem Ave (with street and number) 11/7/48

VS 150

68377 MAITH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Registered No. 68377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD ROAD & HERRING RUN
(c) Hospital or institution:
SYDENHAM HOSPITAL 18 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BRENDA MAITH

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 6 1941

8. AGE: Years	Months	Days	If less than one day
7	5	0	— hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation SCHOOLGIRL

11. Industry or business —

FATHER
12. Name WARREN MAITH
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name LORETTA ROBINSON
15. Birthplace BALTIMORE, Md

16 (a) Informant Warren Maith (Father)
(b) Address 823 W. Saratoga St

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles L. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 8 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1948 to Nov. 6 1948 and that I last saw her alive on Nov 6 1948.

Immediate cause of death	Duration
TUBERCULOUS MENINGITIS	3 weeks
Due to MILIARY TUBERCULOSIS	6 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William E Coot M. D.
Address Sydenham Hosp Baltimore MD Date signed 11/8/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 190

668:578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

668:578
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5603 Carter Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Carter Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. Norris

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Minnie A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 13, 1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
72	5	23		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired R.R.Man
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Howard R. Norris
(b) Address 5603 Carter Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Lorrane Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Filed NOV 8 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1948 to Nov. 5 1948 and that I last saw h-- alive on Nov 3rd 1948

Immediate cause of death Cerebral Apoplexy — Duration 0

Due to Hypertensive Cardio-vascular disease — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E. G. Mayer M. D.
Address 716 Cathedral St Date signed 11-8-48

G68379 1079 11657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

Registered No. G68379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DANIEL Bernard WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George R. Wilson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Viola Banks
15. Birthplace Balto. Md.

16 (a) Informant Viola Banks
(b) Address 1103 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetary
Location Baltimore Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

19 (a) NOV 8 1948 (Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948 at 8:15AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 11/6/48

668380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 668380

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University 15 or 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1331 West Calhoun St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9057

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Jannie Simmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1908

8. AGE: Years	Months	Days	If less than one day
40	4	5	hr. min.

9. Birthplace Winnsboro Fairfield S.C. (town, county and state)

10. Usual Occupation Laborer

11. Industry or business Canton R.R. Co

FATHER

12. Name Will Simmons

13. Birthplace Winnsboro South Carolina

MOTHER

14. Maiden Name Mary

15. Birthplace Winnsboro South Carolina

16 (a) Informant Jannie Simmons

(b) Address 1331 West Calhoun Street

17 (a) (Burial, cremation, or removal) (b) Date thereof November 10, 1948 (month) (day) (year)

(c) Cemetery or crematory Winnsboro South Carolina

Location Fairfield County

18 (a) Funeral director Joseph A. Civicky

(b) Address 66 West Base Street

19 (a) Nov 8 1948 (Date received by registrar) (b) Huntington Park, Maryland (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 4 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1 1948 to Nov 6 1948 and that I last saw h(er) alive on Nov 5 1948

Immediate cause of death: Generalized Carcinomatosis — Duration

Due to probably primary in stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at A M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank E. Slemback M. D.

Address University Hosp Date signed 11/6/48

VS 150

68381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Madison Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 6 ~~Brookwood~~ Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Brookwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mc Hale (THOMAS P. McHALE)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife Mary A Kelly
6 (c) If alive give age years
7. Birth date of deceased (mo., day, yr.) 12/21/1882

8. AGE: Years	Months	Days	If less than one day
66	10	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B & Ohio R.R.

FATHER 12. Name William Mc Hale
13. Birthplace Ireland

MOTHER 14. Maiden Name Hanora Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Mary Mc Hale
(b) Address 604 Brookwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director J. J. Tobin & Sons
(b) Address 1318 Light St.

19 (a) NOV 8 1948 (b) Huntington Williamson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/1948 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/5/1948 to 11/5/1948. and that I last saw him alive on 11/5/1948

Immediate cause of death CARDIO RESPIRATORY FAILURE — Duration

Due to CEREBRAL VASCULAR ACCIDENT

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Shaw M. D.
Address St. Agnes, Md. Date signed 11/6/48

VS 150

668382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

668382
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged & Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Neale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1868

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Neale
13. Birthplace

MOTHER
14. Maiden Name Mary Bugan
15. Birthplace

16 (a) Informant Sister-in-law Home
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Undertaking Co.
(b) Address 900 East Biddle St

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Nov 6 - 1948, and that I last saw him alive on Nov 4 - 1948

Immediate cause of death	Duration
Edema Lungs	days
Due to Cerebral Arterio-Sclerosis	4 yrs
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North ave Date signed 11/8/48

VS 150

668383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1752 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Born in Italy

3 (a) FULL NAME Simone Fortunato

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-5540

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 4 1880

8. AGE: Years	Months	Days	If less than one day
68 67	3	2	hr. min.

9. Birthplace CASAMASSIMA - BARI - ITALY (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name GIUSEPPE FORTUNATO
13. Birthplace ITALY

MOTHER
14. Maiden Name Isabella ?
15. Birthplace ITALY

16 (a) Informant: LENA MANFREDO
(b) Address 1752 HOMESTEAD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 9 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD, BALTIMORE MD

18 (a) Funeral director Frank Della Vecchia
(b) Address 322 S. High St.

19 (a) Filed (b) Registered Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1948 to Nov 6 1948 and that I last saw h[illegible] alive on Nov 6 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Myocardial Insufficiency	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy C. Carozza Jr. M.D.
Address 1 E. Chase St. Date signed 11/6/48

VS 150

G68384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G68384

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fulton & Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 29 (If outside city or town limits write RURAL and give town)

(d) Street No. 36 Overbrook Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Dorothy G. Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-3-1894

8. AGE: Years 54 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert S. Greene (dec.)

13. Birthplace Ohio

MOTHER 14. Maiden Name Flora Lee (dec.)

15. Birthplace Md.

16 (a) Informant John B. Callahan

(b) Address 36 Overbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1210 W. Lombard St.

Nov 8 1945 Date received by local registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1945 at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1945 to 11-5 1945 and that I last saw h[illegible] alive on 11-5 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic c.v. disease with	
Due to a) Mitral stenosis b) Chronic auricular fibrillation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney Johnson Venable M.D.

Address St. Agnes Hospital Date signed 11-5-45

VS 150

G68385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. G68385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 262 S. East Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Robier, Mrs. Frances Jane (Graibel)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/29/85.

8. AGE: Years	Months	Days	If less than one day
63.	7	9	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant Benjamin Robier
(b) Address 262 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Canton Ave & Gat-

18 (c) Funeral director Lilly & Zucker
(b) Address 403 N. Eutaw St.

19 (a) NOV 8 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 7 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1948 to 11/7 1948 and that I last saw her alive on 11/7 1948.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Meningitis due to Torula Histolytica.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature John T. Emmett. M.D.
Address St. Josephs Hosp Date signed 11/7/48 M. D.

VS. 150

G68386

G68386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Dr. & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2329 E. Chase Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3 (a) FULL NAME Daniel Funk

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Veronica Funk

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1898

8. AGE: Years	Months	Days	If less than one day
50	8	20	hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Automobile

FATHER

12. Name John W. Funk

13. Birthplace Md.

MOTHER

14. Maiden Name Mary L. Myers

15. Birthplace Md.

16 (a) Informant Records

(b) Address US MArine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Frederick Rd. Balto. Md.

18 (a) Funeral director Lilly and Zeiler, Inc.

(b) Address 403 S. Wolfe St. Balto. Md.

19 (a) NOV 8 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7, 1948 1948 at 12:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Nov 7 1948, and that I last saw him alive on Nov 7 1948.

Immediate cause of death	Duration
Carcinoma of upper lobe of right lung with metastases	unkn
Due to	
Due to	
Other Conditions Bronchopneumonia, lower lobe of left lung. (Include pregnancy within 3 months of death)	577 da

Date of operation none

Major findings of operation: .....

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature W. C. Robertson M. D.

W. C. Robertson M. D.

Address US MArine Hospital Date signed 11/7/48

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

68387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York,
(c) City or town Hanover (If outside city or town limits write RURAL and give town)
(d) Street No. 9 Sprenkle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fuhrman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Robert
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr) 4-23-03
8. AGE: Years 45 Months 6 Days 13 If less than one day hr. min.
9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business
FATHER 12. Name James Strasbaugh
13. Birthplace Pa
MOTHER 14. Maiden Name Dava Fink
15. Birthplace Pa
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Mechanicstown Pa
18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street
19 (a) NOV 8 1948 (b) Huntington Williams M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948, at 11 05A M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 11/6 1948 and that I last saw her alive on 11/6 1948.

	Duration
Immediate cause of death (1) Shock, etiology undetermined	
Due to (2) Hypertensive Vascular Disease	
Due to (3) Bilateral thrombus cerebral hemorrhage, recent	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman E. Thaler M. D.
Address Johns Hopkins Hospital Date signed 11-7-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G68388

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution: 5 c 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 St. Matthews St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Brinkley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife Ezekiah Brinkley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1896

8. AGE: Years	Months	Days	If less than one day
52	0	3	hr. min.

9. Birthplace Raleigh, N.C. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Emma O'Neil
15 Birthplace N.C.

16 (a) Informant Mrs. Virginia Jackson
(b) Address 1206 St. Matthews St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Baltimore Md.

18 (a) Funeral director Charles B. Law
(b) Address 802 Madison Ave.

NOV 8 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1948 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Nov. 4 1948.
and that I last saw h[illegible] alive on Nov. 4 1948.

Immediate cause of death
Uremia
Due to Hypertension
Due to Cardio vascular disease
Other Conditions Cystitis
Influenza
(Include pregnancy within 3 months of death)

Duration
3 Wks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 11/4/48

VS 150

668389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 668389

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2569 W. Lombard St.

(c) Hospital or institution: 20 04

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2569 W. Lombard St.

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) FULL NAME Frederick C. Leitzman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-12-0163

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie M.

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) July 17 [illegible]

8. AGE: Years 67 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Otto Leitzman

13. Birthplace Germany

MOTHER 14. Maiden Name Selma Gebhardt

15. Birthplace Germany

16 (a) Informant Mrs Annie Leitzman

(b) Address 2569 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10. 48 (month) (day) (year)

(c) Cemetery or crematory Emmanuel

Location Linden Lane

18 (a) Funeral director L. HEEMANN & SON

(b) Address 6067 HARFORD Rd.

19 (a) NOV 8 1948 (b) Huntington Williams, M.D. Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7. 1948. at 2:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946. to Nov 7 1948. and that I last saw him alive on Nov 7 1948

	Duration
Immediate cause of death 1- Acute Pulmonary edema	2 days
Due to 2- Chronic nephritis with hypertension	6 years
Due to	
Other Conditions Cerebral Hemorrhage	4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Nathan Rocemini M. D.

Address 206 S. Gilmor St. Date signed 11-8-48

VS 150

68390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Luerssen Ave.
(c) Hospital or institution: 2 1 0 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Luerssen Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE LUERSSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles F. Luerssen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7th, 1872

8. AGE: Years	Months	Days	If less than one day
76	4 3	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Lieber
13. Birthplace Germany

MOTHER
14. Maiden Name Christiana Shock
15. Birthplace Germany

16 (a) Informant Rev. C.A. Luerssen
(b) Address 4506 Schley Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 [illegible]-1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6th, 1948 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 11-6 1948
and that I last saw h er alive on 19

Immediate cause of death Arteriosclerotic Cardiovascular disease
Due to Chronic Myocarditis
Due to Acute Heart failure
Other Conditions Surgical
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration unable to state
3 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature 10 W. Madison St. M. D.
Address Date signed 11-8-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Springdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS PARVIN ROBERTSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Bertha Thiele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/24/61

8. AGE: Years	Months	Days	If less than one day
87	7	13	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Auto Accessories

11. Industry or business

FATHER
12. Name William George Robertson
13. Birthplace Rockville, Md.

MOTHER
14. Maiden Name Victorine Scott
15. Birthplace —

16 (a) Informant Alice R. Abbott
(b) Address 4404 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Emmett Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 11-6 1948, and that I last saw h— alive on 11-6 1948.

Immediate cause of death: Coronary Occlusion — Duration 1 hr

Due to: Generalized Arteriosclerosis — 15 yrs

Due to: Hypertension — 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Dr Thos P Abbott

Address 4404 Springdale Ave Date signed 11-7-48

VS 150

G68392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G68392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 862 W. Fayette St.
(c) Hospital or institution: 18 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 862 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 25, 1907

8. AGE: Years 41 | Months 7 | Days 12 | If less than one day hr min

9. Birthplace Johnson County N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lonnie Penny

13. Birthplace Johnson Co. N.C.

MOTHER 14. Maiden Name Fredilia Turner

15. Birthplace Johnson Co. N.C.

16 (a) Informant Frank Jones

(b) Address 862 W. Fayette St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof November 8, 1945 (month) (day) (year)

(c) Cemetery or crematory Raleigh

Location North Carolina

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) NOV 8 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 4:38 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to Nov 6 1945 and that I last saw him alive on Oct 25 1945

Immediate cause of death Cardiac Failure — Duration

Due to Valvular Heart Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M.D.

Address 604 N. Fulton Ave Date signed 11/8/45

VS 130

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G68393

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Adelia Mannion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16, 1872

8. AGE: Years	Months	Days	If less than one day
76	7	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant John J. Robinson, Jr.
(b) Address 2127 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-41 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Eutaw and Fayette Sts

19 (a) NOV 8 - 1941 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1941, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1926 to Nov 7 1941, and that I last saw him alive on 11/6 1941.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration 5 yrs

Due to

Due to

Other Conditions Hypertension — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Patterson M. D.
Address 1546 W Balto St Date signed 11/7/41

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68:594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G68:594
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 341 South Chester St.
(c) Hospital or institution: 1-C-S

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 S. Chester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lawrence Walsh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Genevieve O'Connell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/ 1883

8. AGE: Years	Months	Days	If less than one day
65	3	1 0	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Patrolman
11. Industry or business

FATHER
12. Name John Walsh
13. Birthplace

MOTHER
14. Maiden Name Mary Elizabeth Dougherty
15. Birthplace

16 (a) Informant William J. Walsh
(b) Address 2028 Bait St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4900 Frederick Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Baltimore 31, Md.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 6 1948, at 4.47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 22 1948 to NOV 6 1948, and that I last saw h(im) alive on NOV 6 1948.

Immediate cause of death BRONCHO-PNEUMONIA — Duration 12 DAYS
Due to CHRONIC MYOCARDITIS
Due to
Other Conditions ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

(P)
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature James F Kavanagh M.D.
Address 301 McCulloh St Date signed 11-8 48

VS 150

92)

668395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

668395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mount St.
(c) Hospital or institution: Sinai 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 614 S. Rose St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Dembeck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife August
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1917

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name William Lorek
13. Birthplace Balto

MOTHER
14. Maiden Name Helen Kozlouska
15. Birthplace Balto

16 (c) Informant August Dembeck
(b) Address 614 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/78 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Govans Hill Rd

18 (a) Funeral director Tully & Zeth Inc
(b) Address 403 S. Wolfe St

19 (a) (Date received by registrar) 1978 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1978 at 11:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-8 1978 to 11-7 1978, and that I last saw her alive on 11-7 1978.

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to

Other Conditions Bronchopneumonia
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place).
(e) Means of injury

23. Signature Jerome Gabel M. D.

Address Sinai Hosp. Date signed 11-8-78

X

G68396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G68396

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2510 Roslyn Ave.

(c) Hospital or institution: 15-08

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2510 Roslyn Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JANYE C. KONOW

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry C. Konow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 23, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	13	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Seed Analyst (retired)

11. Industry or business J. Bolgiano & Son

FATHER

12. Name John T. Shipley

13. Birthplace Md.

MOTHER

14. Maiden Name Matilda Thompson

15 Birthplace Md.

16 (a) Informant Mr. Harry C. Konow

(b) Address 2510 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948 to Nov 6 1948, and that I last saw h-r alive on Nov 5 1948

Immediate cause of death Carcinoma of Stomach — Duration about 6 mo.

Due to

Due to

Other Conditions Secondary anemia — 2 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Walter D. Lybatt M. D.

Address 2220 Garrison Blvd Date signed Nov. 7 '48

VS 180

G68397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68397

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Clarendon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mayfield W. Veise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, (widowed) or divorced. widowed

6 (b) Name of husband or wife William F. Veise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1889

8. AGE: Years 59 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Samuel J. Widerman
13. Birthplace Woodlawn, Md.

MOTHER
14. Maiden Name Catherine Grill
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. John J. Veise
(b) Address 2807 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEM.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Huntington Williams, M.D.

19 NOV 8 1948 (b) (Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Nov 1948 to 7 Nov 1948, and that I last saw her alive on 7 Nov 1948.

Immediate cause of death: Brain tumor. — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6 Nov 1948

Major findings of operation: Tumor of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Olivery-de Chaudens M.D.
Address University Hospital Date signed 7 Nov 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 North Front Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME CHARLES Charles O. Griffith GRIFFITH

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 8, 1882

8. AGE: Years	Months	Days	If less than one day
65 66	11	29	..... hr. ..... min.

9. Birthplace Berks Co., Pennsylvania
(Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business .....

FATHER
12. Name Jeremiah Griffith
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda Ott
15. Birthplace Pennsylvania

16 (a) Informant Kindt Funeral Home
(b) Address Shillington, Pa.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 11-8-48 (month) (day) (year)

(c) Cemetery or crematory .....
Location Shillington, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore

19 (a) NOV 8 - 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. Nov. 7, 1948, at 7:38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Fred L. Ryan M.D.
Medical Examiner.
Date signed Nov 9 48.

VS 151

B C-248-23923 X ✓ 68399

68399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 68399

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs. 15min.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County BALTO.

(c) City or town Baltimore - 29 (If outside city or town limits, write RURAL and give town)

(d) Street No. 802 Buckfield Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Girl Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr) 11-4-48

8. **AGE:** Years | Months | Days | If less than one day: 2 hr. 15 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alfred L. Jordan

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Elsie M. Rufener

MOTHER 15. Birthplace Ohio

16 (a) Informant Alfred L. Jordan

(b) Address 802 Buckfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS

(b) Address 1827 W. Lexington St. Baltimore, Md.

19 (a) NOV 8 1948 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 . at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 19 48 to 11/4 19 48 and that I last saw her alive on 11/4 19 48.

Immediate cause of death Miscarriage at 20-22 wks.

Due to

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lloyd Rouse Jr. M. D.

Address St. Agnes Hosp. Date signed 11/5/48

Balto Md

VS 159

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. 68400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 27-1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 St Agnes Convent Mt Wash. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sr. Mary Jane Frances RSM.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	15	25 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name T. P. Tibbitts
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Craigh
15. Birthplace Maryland

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month), (day), (year)
(c) Cemetery or crematory Mt. St. Agnes
Location Mount Washington

18 (a) Funeral director H. C. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948 at 12 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Nov. 7 1948 and that I last saw her alive on Nov 6 1948.

Immediate cause of death Cardiac failure

Due to Rheumatic cardio-vascular disease

Due to

Other Conditions Narcolepsy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Zawistki M.D.
Address Mercy Hosp. Date signed 11/7/48

VS 150

G68401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G68401

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Foster Ave
(c) Hospital or institution: 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Walter Page (Wladislaus Paga)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1872

8. AGE: Years 76 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER | FATHER
12. Name Uncle.
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Rose Krawczyk
(b) Address 2606 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director John G. Connelly
(b) Address 416 Eastern Ave.

19 NOV 8 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 1948, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948, to Nov. 6 1948, and that I last saw him alive on Nov. 6 1948.

Immediate cause of death: Myocarditis — Duration: Unknown

Due to: Arteriosclerosis — Duration: unknown

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Ferdinand A. Ross

23. Signature

Address 24 S. Bond

Date signed 11/8/48

VS 150

5102

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 668102

CERTIFICATE OF DEATH 178a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4-07
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country.....

3 (a) FULL NAME RUDOLPH HICKS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace U N (Town, county, and state)
10. Usual Occupation K
11. Industry or business N U

PARENTS
12. Name O N
13. Birthplace W K

MOTHER
14. Maiden Name N N O
15. Birthplace U N

16 (a) Informant.....
(b) Address.....

17 (a)..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School NOV 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address.....

NOV 8 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27, 48 at approx. 5 P.M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas-but unlit oven burner on

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 10/28/48

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

668403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

668403

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 10-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FITZHUGH L. SIMMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August, 1889

8. AGE: Years	Months	Days	If less than one day
59	3	-	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis M. Simms
13. Birthplace Virginia

MOTHER 14. Maiden Name Martha L. Lowe
15. Birthplace Virginia

16 (a) Informant Charles P. Simms
(b) Address 140 McPhail Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington-Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1948, at 2:40 PM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in factory place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski, M.D. M.D.
Medical Examiner.

Date signed 11-7-48

VS 151

G68403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68403
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fitzhugh L. Simms (DOA)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1889

8. AGE: Years (DOA) 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Francis M. Simms
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Martha L. Lowe
15. Birthplace: Virginia

16 (a) Informant: Charles P. Simms
(b) Address: 140 McPahil Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

(a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 19 48 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 11/7/48
(DOA)

VS 181

668404

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 668404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~~University Hospital~~ Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Eutaw St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS J. DEVLIN

3 (b) If veteran, name war ———

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Gorman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1880

8. AGE: Years	Months	Days	If less than one day
68	—	6	hr. min.

9. Birthplace (State) Phila., Pa. (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Arthur Devlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Boyd
15. Birthplace Ireland

16 (a) Informant W. H. Coleman & Son
(b) Address 4731 Lancaster St., Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director John F. ~~Denny~~ Devany, Inc.
(b) Address 715 Light Street

19 (a) (Date received by registrar) (Burlington Williams, M.D.) Registrar

NOV 2 - 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/6/48

3405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 668405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Clifton Pk Ter.
(c) Hospital or institution: 8 o 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Clifton Pk Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Thomas Heiger

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7224

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1886

8. AGE:

Years	Months	Days	If less than one day
62	23	13 14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Car Inspector

11. Industry or business Penna RR

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace France

16 (a) Informant Katherine E. Heiger
(b) Address 3002 Clifton Pk. Terrace

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948, at 1 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1948 to Nov 7 1948. and that I last saw h alive on Nov 5 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. Gordon

Address 3400 E Baltimore Date signed 11/8/48 M.D.

VS 150

68406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68406

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 6m

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2649 Hampden Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA BERDINIA LINS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John G.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1868

8. AGE: Years: 79 | Months: 11 | Days: 12 | If less than one day: hr. ____ min. 1

9. Birthplace: Chicago, Ill (Town, county, and state)

10. Usual Occupation: Houdewife

11. Industry or business

FATHER

12. Name: (Unknown) Lijenberg

13. Birthplace: Sweden

MOTHER

14. Maiden Name: Unknown

15. Birthplace: Sweden

16 (a) Informant: John Lins

(b) Address: 2649 Hampden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)

(c) Cemetery or crematory: Mt Olivet

Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc

(b) Address: 1217 St. Paul St.

19 (a) NOV 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7, 1948 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 11-7 1948 and that I last saw her alive on 11-6 1948.

Immediate cause of death: Generalized Arteriosclerosis — Duration: 10 yrs

Due to:

Due to:

Other Conditions: Cerebral Hemorrhage — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature: Norman R Klemm

Address 3803 Edmondson Ave Date signed 11/8/48

VS 150

8107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 85

Registered No. 668107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General 16-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie A. HORSEMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife David Horseman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	22	hr. min.

9. Birthplace Taylor's Island, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business Home

FATHER
12. Name Frank Spurry
13. Birthplace Md.

MOTHER
14. Maiden Name Virgie Burak
15. Birthplace Md.

16 (a) Informant Mrs. Nina Anzmann
(b) Address 934 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. ms.

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 Edmondson Ave.

NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 7:06 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/8/48

VS 151

8408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73a

Registered No. G68408

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Baltimore Md 11-04

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 442 Druid Court (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Nellie Campher Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1902

8. AGE: Years 45 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Campher

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Brown

15. Birthplace Md

16 (a) Informant Mrs Susie Campher

(b) Address 818 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore, Md

18 (a) Funeral director Mrs Frances A. Hemphill

(b) Address 518 W. Biddle St.

19 (a) NOV 9 - 1946 (Date rec'd by registrar) (b) Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1946, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1942, to 11-6 1946, and that I last saw her alive on 11-6 1946.

Immediate cause of death Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11-8-46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WILLIAM JAMES HARRISON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-07-0087

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Emma

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr): Feb. 5, 1873

8. AGE: Years 75 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace: Harford County, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Waverly Press, Inc.

FATHER
12. Name: George Harrison
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Jane Hitchecke
15. Birthplace: Maryland

16 (a) Informant: Mrs. Florence C. Harrison
(b) Address: 433 Pittman Place - 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory: St. Pauls Meth. Church Cem.
Location: Harkins, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 9 - 1948 (Date rec'd by Registrar) (By) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948 at 2.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948, to 11-8 1948, and that I last saw h IM alive on 11-8 1948.

Immediate cause of death: Duodenal ulcer

Due to: Bleeding

Due to: erosion of the ulcer.

Other Conditions: Arebral Vascular accident.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ulcer of the duodenum

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert C. Herrmann M. D.

Address: West Balto Gen Hosp. Date signed 11-8-48

VS 150

1176

3410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668410

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & John ST
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins apt - St Paul & 31st St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marian Baylies Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1881

8. AGE: Years	Months	Days	If less than one day
67	6	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Henry Hines

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Ella Baylies

15. Birthplace Baltimore Maryland

16 (a) Informant Patient

(b) Address Hopkins Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave, Balto.

18 (a) Funeral director John F Mitchell & Son, Inc.

(b) Address 1900 Eutaw Place

19 NOV 9 - 1948 (Date rec'd by registrar) (b) Langston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1948, to Nov 7 1948, and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Congestive Heart Failure	
Due to Myocardial Infarction	6 days
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Findings above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark S. Hall, M.D.
Address Hosp. Women of Md Date signed 11/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

88411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 66811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp. Hal, Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 01
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN EDWARD STOLL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ada E. Stoll

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1859

8. AGE: Years 88 | Months 11 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Daniel Stoll
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Berger
15 Birthplace Maryland

16 (a) Informant Ada E Stoll
(b) Address 3 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-10-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 NOV 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948, at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 48, to Nov. 7 1948, and that I last saw h.me alive on Nov 7 1948.

Immediate cause of death Chronic Cardiac Failure (due to) Myocardial degeneration — **Duration** ____

Due to Coronary sclerosis — ____

Other Conditions Post operative pneumonia — 9 days

(Include pregnancy within 3 months of death)

Date of operation 10-26-48

Major findings of operation: Cancer of Sigmoid, Hypertrophy & Diverticulosis

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert [illegible] M.D.

Address Mercy Hosp. Date signed 11-7-48

VS 189

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68112

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakland Mills Rd., nr. Liberty Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON M. BENNETT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5632

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Feezer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1902

8. AGE: Years	Months	Days	If less than one day
46	9	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Tree Trimmer
11. Industry or business Gas & Electric Co.

FATHER
12. Name Milton Bennett
13. Birthplace Maryland

MOTHER
14. Maiden Name Mamie Shipley
15. Birthplace Maryland

16 (a) Informan: Mary Feezer
(b) Address Sykesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or ~~XXXXXXX~~ Oakland
Location Carroll Co., Maryland

18 (a) Funeral director WEER & SON
(b) Address

19 NOV 9 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948, at 11:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured ribs
Laceration of lung.
Due to Hemorrhage into chest cavity.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-48 at 11:00 A. M.
(b) Where did injury occur? N. side of Liberty Rd. ½ mile west of Ward's Chapel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from tree-35' to 40'

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11-8-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. 668413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Walnut Ave
(c) Hospital or institution: 28-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Walnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE P RECTOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Renner
13. Birthplace West Virginia

MOTHER
14. Maiden Name Martha -
15. Birthplace -

16 (a) Informant Mr. John W. Rector
(b) Address 1100 Walnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 '48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson AVE & Longwood St

18 (a) Funeral director Harry H. Wehrle
(b) Address 4101 Edmondson Ave.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Hunter-Foster-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Nov. 1948, and that I last saw h[illegible] alive on 1st Nov. 1948.

Immediate cause of death	Duration
Uremia	1 wk.
Congestive heart failure	1 mos.
Due to Generalized Arteriosclerosis	years
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jesse F. Hamburger Jr M. D.
Address Date signed

VS 150

Physicians: please write the causes of death clearly and legibly. Important. Especially important. correct age is especially important.

G68417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Edmondson Ave.
(c) Hospital or institution: 20-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY KULLICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W.	M	WIDOWED

6 (b) Name of husband or wife late Wilhelmina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 '1858

8. AGE: Years	Months	Days	If less than one day
90	4	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baker

FATHER
12. Name - Kullick
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Herman G Kullick
(b) Address 3705 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 '48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19/ 1947, to 11/6/ 1948 and that I last saw him alive on 11/5/ 1948.

Immediate cause of death Arteris sclerotic heart disease — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiss M. D.
Address 1326 Hanover St. Date signed 11/9/48

VS 150

415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ months
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E. 30th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Agnes Markiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/29/95

8. AGE: Years	Months	Days	If less than one day
53 52	1	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Trzcinski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Malinowski
15. Birthplace Poland

16 (a) Informant Frank Markiewicz
(b) Address 1730 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 200 Eastern ave

NOV 9 - 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1948, at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Nov 8 1948 and that I last saw her alive on Nov 8 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Hypertensive Cardio	
Due to & Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Pierson Jr. M. D.

Address Date signed

VS 150

8416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 68416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Gold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Parkville Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Garden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Turner A. Raynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	divorced

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 9, 1872

8. AGE: Years	Months	Days	If less than one day
76	2	28	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Alburn Raynes
(b) Address Garden Ave. Fullerton P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 19 48 to Nov 6 1948; and that I last saw him alive on Nov. 4 1948

Immediate cause of death: Carcinoma - Sigmoid Colon — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Norman R Klemm M.D.
Address 3803 Edmondson Ave Date signed 11/5/48.

68317 Hal 5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. 68317

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hillman Ct (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Hakesley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella P.
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) 10-31-69

8. AGE:	Years	Months	Days	If less than one day
	79	1	6	hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Retired salesman
11. Industry or business

FATHER
12. Name Edward Hakesley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvista McComas
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (c) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto
18 (a) Funeral director L. J. Tuck
(b) Address 5305 Harford Rd
19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6- 1948 at 8:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948 to 11-6 1948, and that I last saw him alive on 11-4 1948

CERTIFICATION APPROVED BY

	Duration
Immediate cause of death Cerebral Embolism	
Due to Hypostatic pneumonia	
Due to Senility, fracture neck of left hip	
Other Conditions	

E. K. Krieger M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: T. B. of lungs

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-31-48 at 12 PM
(c) Where did injury occur? Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) (While at work) no
(e) Means of injury fall slipped on rug fell to floor
23. Signature N K Krieger M. D.
Address Johns Hopkins Hosp Date signed 11-7-48

VS 150

68218 BC-48-15269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

64

Registered No. 68218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DO A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WARDEN ALEXANDER GIBSON, JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr) July 1948

8. AGE: Years	Months	Days	If less than one day
	4	—	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Warden Alexander Gibson, Sr.

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Dorothy Wilson Gibson

15. Birthplace Balto., Md.

16 (a) Informant Warden Alexander Gibson, Sr.

(b) Address 1128 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948

(c) Cemetery or crematory Mt. Zion Am.

Location

18 (a) Funeral director Mrs Katie K. Williams

(b) Address 322 N Schroeder St

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Upper respiratory infection.

Status thymico lymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? (White or negro)

(d) Means of injury

23. Signature Thos. A. C. Norris M.D. Medical Examiner.

Date signed 11/8/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. X68419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRISON COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1898

8. AGE: Years 50 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Leesburg, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alfred Cooper
13. Birthplace Leesburg, Va.

MOTHER
14. Maiden Name Lena Brown Cooper
15. Birthplace Leesburg, Va.

16 (a) Informant Lena Cooper
(b) Address 2500 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director MRS. KATIE B. WILLIAMS
(b) Address 322 N. Schroeder St.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948 at 8:30AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.

Date signed 11/6/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668420

8 1a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30hr

(e) Length of stay in Baltimore (yrs., mos., or days) 11 0 4

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL, and give town)

(d) Street No. 420 Valley Court (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Irvin West.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Married

6 (b) Name of husband or wife Geneva West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1909

8. AGE: Years	Months	Days	If less than one day
38	10	14	hr. min.

9. Birthplace Centerville Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name A. Harrison West

13. Birthplace Balto Md

MOTHER

14. Maiden Name Dolly Blake

15. Birthplace Centreville Md.

16 (a) Informant A. Harrison West

(b) Address 1398 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

16 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Nov 1948, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Nov 1948, to 7 Nov 1948, and that I last saw him alive on 7 Nov 1948.

Immediate cause of death Pneumococcus Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard D Hoover M. D.

Address Univ Hospital Date signed 7 Nov 48

VS 150

68421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 68421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address The Warrington Apts.
(c) Hospital or institution: 3908 N. Charles St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EILERT HERMAN KOESTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Lisette Koester
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1855
8. AGE: Years 93 | Months 1 | Days 11 | If less than one day: hr. min.
9. Birthplace Oldenburg, Germany (Town, county, and state)
10. Usual Occupation Chairman of Board
11. Industry or business E. H. Koester Bakery Co.

FATHER
12. Name Gerhard Koester
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Duser
15. Birthplace Germany

16 (a) Informant Mr. William H. Koester
(b) Address 650 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Mausoleum
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Nov. 9 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1948, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24/48 to 11-1-1948 and that I last saw h[illegible] alive on 11-1 1948

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: 8 yr.
Due to Uremia congenital Urinary calculus — 14 days
Due to Acute heart failure Antemortem — 7
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luther E. Little M. D.
Address 10 W. Madison St. Date signed 11-8-48

LUTHER E. LITTLE

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

58422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 668422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Denison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD WILFRED VOLMAR

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Albina Volmar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26, 1908

8. AGE: Years	Months	Days	If less than one day
40	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Rubber Stamp Mfgs.
11. Industry or business Self

FATHER
12. Name William Volmar
13. Birthplace Balto.

MOTHER
14. Maiden Name Jane Miller
15. Birthplace Eng.

16 (a) Informant Mrs. Albina Volmar
(b) Address 405 Denison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 9 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 6.55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1946 to Nov 8 1948.
and that I last saw him alive on Nov. 7 1948.

Immediate cause of death	Duration
Malignancy of Lung	2 yrs.
Due to (a) Bronchogenic Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov. 1946
Major findings of operation: Pneumonectomy
Cancer of Bronchus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.W. Jacobsx M. D.
Address 2310 Eutaw Place Date signed 11-8-48

VS 130

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 68423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 Rosedale St.
(c) Hospital or institution: — 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto.
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Minnie A. Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married

6 (b) Name of husband or ~~wife~~: J. Edw. Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 9, 1877

8. **AGE:** Years 71 | Months 3 | Days 28 29 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. J. Edw. Hoffman (Husband)
(b) Address 1536 Rosedale St.

17 (a) Burial (b) Date thereof 11-10-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, MD

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address Balto. MD.

19 (a) NOV 9 1948 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1946 to Nov 7 1948, and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death: Carcinoma of breast with Metastasis

Duration: 2 yrs

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Ernest N. Kahn

Address 1730 Eye & Ear Hosp. Date signed 11/9/48 (M) (D)

VS 150

G68424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68424

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 Sarah Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1901

8. AGE: Years 47 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Clayton, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Demison Richardson
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant David Jones (husband)
(b) Address 1041 Sarah Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Monroe St.

19 (a) NOV 9 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948, at 10:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to Hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D. (Medical Examiner)
Date signed 11-6-48

VS 191

X

668425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 E. Federal St.
(c) Hospital or institution: 8 66

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John M. Cavanaugh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1948, at 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 11/8 1948
and that I last saw h alive on 19

Immediate cause of death Bronchopneumonia — Duration

Due to Arteriosclerotic C-V.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	
Male	White	Married	

6 (b) Name of husband or wife Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 15th 1887

8. AGE: Years	Months	Days	If less than one day
61	2	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Retired

FATHER
12. Name Thomas Cavanaugh
13. Birthplace Cumberland Md.

MOTHER
14. Maiden Name Margaret Welsh
15. Birthplace Cumberland Md.

16 (a) Informant Mrs Mary A. Cavanaugh
(b) Address 1826 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Coyan & Son
(b) Address 901-03 Hollins St.

NOV 9 1948 (Date received by registrar) (by) Huntington Williams, M.D. Registrar

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian F. Liebl
Address 11 W. Biddle St. Date signed 11/8/48 M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68426

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: I726 N.Wolfe Street
(c) Hospital or institution: 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: I726 N.Wolfe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Claude H.Atzrodt

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 214-01-9881

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Minnie Widerman

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Nov.3rd.,I876

8. AGE: Years	Months	Days	If less than one day
72	0	4	########## min.

9. Birthplace: Hanover,Pennsylvania (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Ship Yard Clerk

FATHER
12. Name: Harry Atzrodt
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Anna McFarland
15. Birthplace: Virginia

16 (a) Informant: Mrs.Minnie Atzrodt (Wife)
(b) Address: I726 N.Wolfe Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** II/I0/48 (month) (day) (year)
(c) Cemetery or crematory: Mt.Olivet
Location: Hanover,Pennsylvania

18 (a) Funeral director: George J.Ruth,Inc.
(b) Address: I735 Harford Avenue

19 (a) NOV 9 1948 **(b)** Huntington Williams, M.D. (Registered by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th., 19 48 at 11 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov. 7 1948. and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions [illegible]	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

Signature Conrad L. Richter M. D.
Address 1206 N. Wash. St. **Date signed** 11/8/48

Conrad L. Richter

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 N. Bond Street
(c) Hospital or institution: 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 N. Bond Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mary Frances Moore (Mollie F. Moore)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18th., 1867

8. AGE: Years 81 | Months 8 | Days 20 | If less than one day ########## min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Daniel Moore
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Lacy
15. Birthplace Ireland

16 (a) Informant Mrss. Anna T. Moore (Sister)
(b) Address 1517 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue, Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Nov. 7 1948 and that I last saw her alive on October 11 1948

Immediate cause of death Myocarditis of Heart — Duration about 2 years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kate T. Prompt M.D.
Address 1623 E. N. Ave. Date signed 11/8/48

V S 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

Registered No. G68428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Josephs Hosp. 9-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Chilton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella Agnes Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/85

8. AGE: Years 63 Months 8 Days 24 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business Title Company

FATHER
12. Name John Wicht
13. Birthplace St Louis, Mo

MOTHER
14. Maiden Name Mary E. Kerr
15. Birthplace Baltimore

16 (a) Informant William M. Murphy
(b) Address 1710 Chilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Chas. F. Evans Son
(b) Address 118 W Mt Royal Ave

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 7 1948 and that I last saw h[illegible] alive on Nov 7 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Coronary Thrombosis	
Due to Arterio-sclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Guy E. Rusca Jr.
Address St Josephs Hosp. Date signed 11/7/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

8129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

Registered No. 668129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison-Sts Linden Ave
(c) Hospital or institution: Maryland General Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 2635 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RETA GRAHAM

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John A Graham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17 1868

8. AGE: Years 6. | Months 7 | Days 3 21 | If less than one day hr. min.

9. Birthplace Queen Annes Co. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James E. Reynolds
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Rhodes
15. Birthplace Maryland

16 (a) Informant John A. Graham SR
(b) Address 2635 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Pleasant St Baltimore, Md

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 07 NOV 1948 at 3 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 OCT 1948 to 7 NOV 1948. and that I last saw HER alive on 7 NOV 1948.

Immediate cause of death: CARDIORESPIRATORY FAILURE — Duration: 2 HOURS

Due to CARCINOMA - RIGHT LUNG & METASTASIS — 1 YR??

Due to LEFT LUNG, PLEURA, PERICARDIUM, MYOCARDIUM, & SPLEEN.

Other Conditions: BILATERAL PLEURAL EFFUSION (Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: SEE ABOVE

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen Hosp Date signed 7 Nov 48

VS 190

68430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. 68430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33 Dolphert
(b) Street address ~~2606 Maryland~~ 1701
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Maryland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MR. DANIEL KILLEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-5600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	MARRIED

6 (b) Name of husband or wife Mrs. Delia Killen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) May 1, 1883

8. AGE: Years	Months	Days	If less than one day
64	6	6	— hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER	12. Name	Thomas Killen
	13. Birthplace	Ireland
MOTHER	14. Maiden Name	Katherine Daily
	15. Birthplace	Maryland

16 (a) Informant Wife
(b) Address 2606 Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK R

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 118 W Mt. Royal Ave

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at 2:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948, to Nov. 7 1948, and that I last saw him alive on Nov. 7 1948.

Immediate cause of death	Duration
Cardiac + Resp. failure	
Due to Perforated Duodenal Ulcer with hemorrhage	
~~Due to~~ Coronary Thrombosis with infarction of Myocardium	
~~Other Conditions~~ Arteriosclerotic Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: as above

PHYSICIAN
* Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee III
Address Union Memorial Hosp Date signed 11/7/48 M. D.

668431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Tiffany Court
(c) Hospital or institution: 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Tiffany Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD WALKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-05-5368

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1886

8. AGE: Years 62 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Benj. Walker
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Alston
15. Birthplace N.C.

16 (a) Informant Leola Walker (Wife)
(b) Address 1035 Tiffany Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ann Arundel County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Funeral for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7th 1948, at 6:10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1/48 to 11/7/48 and that I last saw him alive on 11/7/48.

Immediate cause of death: Cardiac Renal. Duration 1 Month
Due to Interstitial Nephritis Chron.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Guinn M.D.
Address 522 N. Wolfe St. Date signed 11/8/48

VS 159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

668432

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. & Cl
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Eutaw Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Mahrer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Catherine Mahrer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1892

8. AGE: Years 55 | Months - | Days 16 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Secretary to Congressman

11. Industry or business

FATHER 12. Name Joseph Mahrer

13. Birthplace unknown Balto.

MOTHER 14. Maiden Name Mary Walker

15. Birthplace unknown Balto.

16 (a) Informant Hosp. records

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 10 48 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER - CEM

Location 4300 BELAIR RD

18 (a) Funeral director DIPPEL BROS

(b) Address 1800 E LOMBARD ST

19 (a) NOV 9 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at 8 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 19 48 to Nov. 7 19 48 and that I last saw h[illegible] alive on Nov. 7 19 48

Immediate cause of death Acute coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature T. Dwinski

Address Mercy Hosp. Date signed 11/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G68433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68433

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS BRONIKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1096

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Irmalee
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	5	hr. min.

9. Birthplace Sayersville, N.J. (Town, county, and state)

10. Usual Occupation Freight Handler
11. Industry or business Transportation

FATHER
12. Name Joseph Bonikowski
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Wojciechowski
15. Birthplace Poland

16 (a) Informant Mrs. Irmalee Bronikowski
(b) Address 1721 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Taylor Avenue

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1505 Eastern Avenue

19 (a) NOV 9 - 1948 (rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1948, 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Bryan M.D. Medical Examiner

Date signed November 8, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668434 H 24
4E

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

668434 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Taboro (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ronald M. Hatch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-5-48

8. AGE: Years	Months	Days	If less than one day
	8	4	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Frederick Hatch
13. Birthplace Canada

MOTHER
14. Maiden Name Allene R. Lowry
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Nov 9/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Taboro Memorial Park
Location Taboro N C

18 (a) Funeral director Tillett Funeral Home
(b) Address 200 E College St Burlington N C

19 (a) NOV 9 - 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1948 at 3:45-a M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25-1948 to 11-9 1948, and that I last saw him alive on 11-9 1948.

Immediate cause of death: Cystic fibrosis of the pancreas, chronic with pulmonary fibrosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M. D.
Address Johns Hopkins Hosp Date signed 11-9-48

VS 150

668435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 170c

668435 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits write RURAL and give town)
(d) Street No. 1223 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD RIVERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1890

8. AGE: Years 58 | Months 8 | Days 16 | If less than one day hr. min

9. Birthplace Florence, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Andrew Rivers
13. Birthplace Florence, S. C.

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Florence, S. C.

16 (a) Informant Lillian W. Kier
(b) Address 1036 W. Fayette St., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winder

18 (a) Funeral director Charles H. Alexander
(b) Address 1209 McCulloh St, Balto, Md.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1948 at 2 40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Concussion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 6, 1948 at 12 P. M.
(b) Where did injury occur? 1223 McCullough St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ran struck by taxicab

23. Signature Earl L. Royster M.D. Medical Examiner.
Date signed Nov. 7, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 68436

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 480 N Wright Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Patrick Harris

3 (b) If veteran, name war: Nil
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 22, 1932

8. AGE: Years	Months	Days	If less than one day
16	6	17	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation news Salesman
11. Industry or business

FATHER
12. Name William H Harris
13. Birthplace North Carolina

MOTHER
14. Maiden Name Gladys Willard
15. Birthplace North Carolina

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto Md

18 (a) Funeral director A Eugene Evans
(b) Address 1500 W Baltimore St

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Acute pul. edema & consolidation RUL — Duration

Due to ? Pul. infection, ? Pneumonia

Due to

Other Conditions RHD & Mitral stenosis & insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Pul. Edema & consolidation RUL RHD & Mitral & Tricuspid stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address The Johns Hopkins Hosp Date signed 11/9/48

VS 180

G68437
Dr. Golley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G68437
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Ailsa Avenue
(c) Hospital or institution: 2203
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Ailsa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ACHTERKIRCHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1874

8. AGE: Years	Months	Days	If less than one day
74	10	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Hohmann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schroeder
15. Birthplace Germany

16 (a) Informant Mr. Wm. Achterkirchen
(b) Address 2600 Ailsa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Washington, D.C.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 11/9 1948
and that I last saw h[illegible] alive on 11/9 1948

Immediate cause of death Coronary Thrombosis (Hypertension)

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury.

23. Signature [illegible] M.D.
Address 5702 Harford Rd Date signed 11-9-48

X

VS 189

668438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

668438 Registered No.

CM 102317

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Washington ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Hankey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Eugene Hankey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1869

8. AGE: Years	Months	Days	If less than one day
79	5	24	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Conner
13. Birthplace MD.

MOTHER
14. Maiden Name Lydia Harrison
15. Birthplace MD.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) NOV 9 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 8- 1948 12.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6- 24- 1946 to 11-8- 1948, and that I last saw BR alive on 11- 8 - 1948

Immediate cause of death Cardiac Failure — Duration 2 mos?

Due to Arteriosclerotic Heart Disease — 4 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jernigan M. D.
Address BALTIMORE CITY HOSP Date signed 11-8-48

68439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G68439 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-1506

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Margarett E. Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1876

8. AGE: Years	Months	Days	If less than one day
72	9	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Sec. Manager
11. Industry or business Ind. Retail Grocer's Assoc

FATHER
12. Name George W. Walker
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella P. Anthony
15. Birthplace Maryland

16 (a) Informant Mrs. Margarett E. Walker
(b) Address 2601 E. Biddle Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Boulevard

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street.

19 NOV 10 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by local reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1948, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 8 1946, to 11 8 1948, and that I last saw h[illegible] alive on 11 8 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 hr
Due to: Arterial Arteriosclerosis — Hyp
Due to:
Other Conditions: Mitral Regurgitation — 6 yrs
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Miller M.D.
Address 1500 N Bdwy Date signed 11/9/48

97

G68440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68440

GM. 96573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hollins ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March. 14-1879

8. AGE: Years	Months	Days	If less than one day
69	7	22	hr. min.

9. Birthplace Lituania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent. Miller
13. Birthplace Lithuania

MOTHER
14. Maiden Name Annie ?
15. Birthplace Lituania

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kassuston Sons
(b) Address 602 S. Paca St.

19 NOV 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 6 - 1948 at 11.45 MP

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 9- 1945 to 11- 6- 1948.
and that I last saw h in live on 11- 6- 1948.

Immediate cause of death	Duration
CARDIAC FAILURE	6 MOS
Due to SYPHILITIC HEART DISEASE	3 YEARS
Due to 2 AORTIC INSUFFICIENCY	
Other Conditions TABES DORSALIS	3 YEARS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP. Date signed 11-7-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 569

G68441
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Marseilles Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day, hr.	min.
65				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Fay
15. Birthplace Russia

16 (a) Informant Ray Gordon
(b) Address 1720 Marseilles Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill

18 (a) Funeral director Jack Lewayne
(b) Address 2150 Estaw Place

19 NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-1948 to 11-9-1948, and that I last saw him alive on 11-9-1948.

Immediate cause of death Post-operative (craniotomy) shock

Due to Meningioma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan M. Eustace M. D.
Address Sinai Hospital, Md. Date signed 11-10-48

68442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 H

Registered No. 68442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Do A
(e) Length of stay in Baltimore (yrs., mos., or days) 50yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Brookfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY SNYDERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Poland

MOTHER
14. Maiden Name: Rebecca
15. Birthplace: Poland

16 (a) Informant: Sylvan Snyderman
(b) Address: 3661 Wabash Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-10-48 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 NOV 10 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 9/48 at approx. 9 A.M.
(b) Where did injury occur? 2212 Brookfield Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Mouth to gas outlet

23. Signature M.D.
Medical Examiner.
Date signed 11/9/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

✓ 68443 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Spring Hill Ave #15
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Springhill Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Gumenick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name Hinda
15. Birthplace Russia.

16 (a) Informant Rose Gumenick
(b) Address 2908 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis, Inc
(b) Address 2100 Eutaw Place
Huntington Williams M.D. Registrar

NOV 10 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 6 45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1948 to Nov 9 1948, and that I last saw h alive on Nov 9 1948.

Immediate cause of death Bullous emphysema — Duration

Due to

Due to

Other Conditions not determined

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: to be done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Hunter M. D.
Address Sinai Hospital Date signed Nov. 9 1948

Chas. Silverstein ×

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68434

To be approved by medical examiner 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louisa Brendel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1863

8. AGE: Years	Months	Days	If less than one day
85	8	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Michelman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Weidmeier
15. Birthplace Germany

16 (a) Informant Anna Brendel
(b) Address 1012 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Washington Blvd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 8 1948, and that I last saw h[illegible] alive on Nov 8 1948

Immediate cause of death: Hypertensive Cerebrovascular disease — Duration 2 days

CERTIFICATION APPROVED BY

Due to

Earl K. Rose M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Due to Fracture surgical neck R humerus Duration 32 yrs

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 1, 1948 at ? A.M
(c) Where did injury occur? 1012 S. Ellwood Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down steps, inside

23. Signature Daniel L. Feinstein M.D.
Address West Balto Hosp Date signed 11/8/48

VS 150

68445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G68445
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N. Carey st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa A. Mackey

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Robert J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 1st 1876
8. AGE: Years 72 | Months 7 | Days 8 | If less than one day: hr. mjn.
9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name J. Thomas Duffy
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Mary E. O'Connor
15. Birthplace Ireland

16 (a) Informant Mrs Nellie T. Roche
(b) Address 123 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Richmond Va

18 (a) Funeral director John J. Convanson Son
(b) Address 901-03 Wallis St

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1948 at 2 45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 27th 1948 to Nov. 9- 1948 and that I last saw h alive on Nov. 9- 1948

	Duration
Immediate cause of death Cerebral apoplexy	12 hrs.
Due to arteriosclerosis	3 yrs
Due to Chronic nephritis	3 yrs
Other Conditions Arthritis.	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Eutaw Place Date signed 11/10/48

VS 150

X

68446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

Registered No. G68446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Freemount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Freemount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Owen R. Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1868

8. AGE: Years 80 | Months 7 | Days 15 16 | If less than one day: hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Smith
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Mary Willows
15. Birthplace Frederick, Md.

16 (a) Informant Eloise Turner
(b) Address 79 St. Nicholas Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Jno. George W. Holland
(b) Address 1601 Druid Hill Ave.

19 (NOV 10 1948) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 19 48 at 1:45 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or public place? While at work?
(d) Means of injury

23. Signature John R Waters M.D.
Medical Examiner.
Date signed 11/6/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68447
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Woodington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB SCHIECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26, 1873

8. AGE: Years	Months	Days	If less than one day
74	11	14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Retired bartender
11. Industry or business Miller Bros. Restaurant

FATHER
12. Name John Jacob Schieck
13. Birthplace Germany

MOTHER
14. Maiden Name Alize Kron
15. Birthplace Germany

16 (a) Informant Franklin Square Hospital Records
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12-48 (month) (day) (year)
(c) Cemetery or crematory Forest Hill
Location Washington Blvd

18 (a) Funeral director Otto Blake
(b) Address Washington Blvd

19 (a) NOV 10 1948 (b) [signature] for Williams, M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948 at 12:08 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease.
~~Due to~~ History of chronic alcoholism.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George T. Merrill M.D.
Medical Examiner.
Date signed 11-10-48

Please write plainly, with undading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G68448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G68448 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Elliott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Theresa McAvoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fe. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1865

8. AGE: Years 83 | Months 6 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas McAvoy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Dunne
15. Birthplace Ireland

15 (c) Informant Mary E. McAvoy
(b) Address 3006 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd
18 (a) Funeral director John R. Moran
(b) Address 2060 E. Balt. St.

NOV 10 1948 (Registered by registrar) Kensington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/ 1948 to 11/8/ 1948, and that I last saw her alive on 11/8/ 1948.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Cardiac & pulmonary congestion

Due to - Contusion of chest

Other Conditions - Staphylococcus aureus Bottle

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Eugene L. Feldman, M.D.
Address 18 S. Hoyt St. Date signed 11/8/48

G68449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G68449
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Cator Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Cator Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Duke Tilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frank H. Tilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-1855

8. AGE: Years	Months	Days	If less than one day
93 94	8	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustan H. Duke
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Rosenstiel
15. Birthplace Maryland

16 (a) Informant Mrs. Chas. T. Donnelly
(b) Address 618 Cator Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Govans
Location Homeland Ave.

18 (a) Funeral director John L. Moran
(b) Address 3000 E. Baltimore St.

19 (a) Washington Nelligan, M.D. Registrar
(Date rec'd by registrar)

NOV 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948 at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to Nov 8 1948 and that I last saw h alive on Nov 8 1948.

Immediate cause of death Chronic Myocarditis — Duration 3 yrs

Due to

Due to

Other Conditions Acute Cardiac Dilation — 1948

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. W. Bishop M. D.
Address 503 Sheridan Ave Date signed Nov 9-48

X

DEATHS WITHIN TWENTY-FOUR HOURS. Every effort should be made to obtain correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68450
LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12 B

Registered No. G68450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3485 Fairsun Court
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Bush

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Seperated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1904

8. AGE: Years	Months	Days	If less than one day
44	8	24 23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Stock
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12. 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Park C. B. M. Walter
(b) Address Park & Clayton Sts Huntington Williams, Mgr

19 (a) (Date received by Registrar) (b) Registrar

NOV 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/48 19 , at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 to 11/9/48 19 , and that I last saw her alive on 11/9/48 19 .

Immediate cause of death	Duration
Coronary thrombosis	4 hrs.
Due to ?	
Due to Far Advanced Pulmonary Tuberculosis	6 yrs.
Due to	6 yrs.
Other Conditions Diabetes M.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed 11-7-48

G68451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68451
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 W. 40th St. Balto 11 md. (If rural give location)
(e) Citizen of foreign country? W No (Yes or No)
If yes, name country

3 (a) FULL NAME G. Ridgely Sappington (G. RIDGELY SAPPINGTON)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs. Anne Richter Sappington
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Feb. 4, 1883
8. AGE: Years 65 | Months 10 | Days 5 | If less than one day hr. min.
9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Law
FATHER 12. Name Francis R Sappington
13. Birthplace Maryland
MOTHER 14. Maiden Name Marie John
15. Birthplace Maryland
16 (a) Informant Hospital record and Mrs Sappington
(b) Address 606-W-40-St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville.
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (H. F. MOWEN SUC.) 100 W. NORTH AVENUE
19 (a) 11 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 9 40 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Acute Congestive Heart Failure	3 days
Due to Damaged myocardium from old coronary - c	6 yrs.
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John R. Smith, Jr. M. D.
Address Union Memorial Hosp Date signed 11/9/48

VS 150

X

G68452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G68452
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert and Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 25
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1212 St Paul St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: MARGARET B. McBRIARTY

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: John Mc Briarty
6 (c) If alive, give age: dec years

7. Birth date of deceased (mo., day, yr.): 3-7-1865

8. AGE: Years	Months	Days	If less than one day
83	8	2	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Alphonse Beil
13. Birthplace: Bavaria

MOTHER
14. Maiden Name: Not obtainable ?
15. Birthplace: Bavaria

16 (a) Informant: Miss Barbara Mc Briarty (daughter)
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Md.

18 (a) Funeral director: H. W. Meade and Son
(b) Address: 805 N. Calvert St.

NOV 10 1948 (Date rec'd by registrar)

(Signature for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 9 - 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-1948 to 11-9-1948, and that I last saw her alive on 11-9-1948.

Immediate cause of death	Duration
Cardiac failure.	
Congestive.	
Due to Bronchopneumonia	6 days
Due to	
Other Conditions Emphysema arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Allyn F. Judd M. D.
Address: Mercy Hospital Date signed: 11-9

CX

VS 150

FOR CORRECTIONS, WITH ONE ALONG LINE. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G68453
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Susan Parker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June [redacted] 1880

8. AGE: Years	Months	Days	If less than one day
68	5	6	hr. min.

9. Birthplace Davis Wharf Accomac Co. Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Parker.
13. Birthplace Accomac Co. Va.

MOTHER
14. Maiden Name Janie West.
15. Birthplace Accomac Co. Va.

16 (a) Informant Eula Davenport.
(b) Address 1128 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) (b) Registrar

NOV 10 1948

Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1948 to Nov 7 1948. and that I last saw her alive on Nov 5 1948.

Immediate cause of death Respiratory failure

Due to Arteriosclerotic Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shirokofsky M.D.
Address 601 N. Monroe St. Date signed 11/9/48 M/D

G68454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St. 19-2
(c) Hospital or institution: Aged Women's & Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) Entered Home Sept 22 1947
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 West Lexington St (If rural give location) Bal.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew B. Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 11 1867

8. AGE: Years 81 | Months 2 | Days 30 | If less than one day ... hr. ... min.

9. Birthplace Harford Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Josephus B. Reed
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Cassandra Ann Dowbow
15. Birthplace Harford Co Md

16 (a) Informant A. E. Reed Supt.
(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Maddonna

18 (a) Funeral director Masters & Krug
(b) Address Parkedale Md

NOV 10 1948 (Date rec'd by registrar)
(b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 2 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to November 1948, and that I last saw h.i.m alive on Nov. 10 1948

Immediate cause of death Cardiac Failure — **Duration**

Due to Coronary Thrombosis

Due to

Other Conditions Arteriosclerotic gangrene of extremities

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Edward Day M.D.
Address 4-E-33rd St-18 Date signed Nov. 10, 1948

V S 150

G68455 G68455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave.
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Belle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Slossberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	6	25	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Samuel Levy
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Louis Slossberg
(b) Address 3804 Belle Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11/48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Avenue

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) (Date rec'd by Registrar) NOV 11 1948 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 10 1948 and that I last saw h alive on Nov 10 1948

Immediate cause of death: Acute Cerebral Hemorrhage — Duration

Due to Ch Hypertention

Due to Ch myocarditis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. L. Hornstein M.D.

Address 704 E. Biddle St. Date signed 11/11/48

X

G68456
LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Broadway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Shirey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/24/1877

8. AGE: Years	Months	Days	If less than one day
71	2	17	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Virginia

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St
NOV 11 1948 Baltimore (Maryland), Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 , at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/48 19 , to 11/10/48 , and that I last saw h er alive on 11/10/48 19

Immediate cause of death pneumonic abscess — Duration 2 weeks

Due to

Due to

Other Conditions Diabetes Mellitus — 20 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Reichold M. D.
Address Balto City Hosp. Date signed 11-10-48

1332

VS 150

668457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

668457

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Greenmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA B. PEILAND

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1879

8. AGE: Years	Months	Days	If less than one day
69	1	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Ruark
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Guthrie
15 Birthplace Md

16 (a) Informant Mrs J. Cowan
(b) Address 1311 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) ..... (b) .....
(Date rec'd by registrar) (Registrar)

NOV 1 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to Nov 9 1948
and that I last saw her alive on Nov. 9 1948-2 P M

Immediate cause of death: Acute Cardiac Failure — Duration

Due to Arteriosclerotic Cardio-

Due to Vascular disease.

Other Conditions Bronchiectasis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature L. B. Stevens
Address 3400 Cedarcroft Rd. Date signed 11/10/48 M D

X

G68458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 82a

G68458 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in this record and signature of informant must be in ordinary signature. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and not initials. If married, widowed or divorced, state also the name of husband or wife. If death occurred in a hospital or institution, give its name instead of street and number. The entries must be carefully and correctly made. Please answer all questions. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 N. East Avenue
(c) Hospital or institution:

26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. East Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Frances Maccis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or ~~wife~~ Martin Maccis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/23/1884

8. AGE: Years	Months	Days	If less than one day
63	10	17	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Skodmin
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Victoria McClelland-dght
(b) Address 435 N. East Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Holy Redeemer
Location 4430 Belair Rd. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

~~NOV~~ 11 1948 (b) Washington Williams, M.D.
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1948 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Oct~~ 1948 to 11/9 1948 and that I last saw her alive on 11/5 1948

Immediate cause of death Paralysis Duration 48 hrs
Hemorrhage of Brain

Due to

Due to

Other Conditions High Blood Pressure
Hardening of Arteries
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify)
(e) Means of injury X

23. Signature D A.C. Heaver, M.D.
Address 3701 Fairmount Blvd
11/9/48

VS 159

668459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

668459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 N. Duncan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Duncan Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Prokop Pernica

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of ~~husband~~ or wife Veronica (nee Shimek)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	4	4		

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Veronica Shimek Pernica
(b) Address 127 N. Duncan Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 11 1948 Huntington Williams (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1948, at 9:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Nov 8 1948
and that I last saw h[illegible] alive on Nov 8 1948

Immediate cause of death: Myocardial degeneration — Duration
Due to: Arteriosclerosis - generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Kleiner M. D.
Address 762 E. Monument Date signed 11/9/48

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be entered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

668460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132. Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 - PENNA. AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Reverend Reese
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-05-8469

4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: WIDOWER
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JUNE 10, 1896
8. AGE: Years 52 Months 5 Days - If less than one day hr. min.
9. Birthplace KENT CO. MD. (Town, county and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant THOMAS TAYLOR
(b) Address 1132 - PENNA AVE

17 (a) BURIAL (Burial, cremation or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director A. Pollard
(b) Address 1 [illegible] Druid Hill
19 (a) NOV 11 1948 Arlington Mortuary
(Date rec'd by registrar) Registrar

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948, to 1948, and that I last saw him alive on Nov. 9 1948

Immediate cause of death: Hypostatic pneumonia — Duration: 3 days.
Due to Arteriosclerotic cardiovascular disease.
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce V. Benjamin
Address 1837 Edmondson Date signed 11/9/48 M.D.

668461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 D

668461

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2577 W. BALTIMORE ST

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County —

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2577 N BALTIMORE ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George BEAL

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-2169

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Leith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name ? Beal

13. Birthplace Leith

MOTHER 14. Maiden Name ?

15. Birthplace Leith

16 (a) Informant Anna Beal

(b) Address 2577 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 -48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Belair Rd

18 (a) Funeral director Joseph Lasanakos Jr

(b) Address 602 Washington Blvd

NOV 11 1948 (Date rec'd by registrar) (b) Huntington Hall Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948, at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 25 1948 to November 8 1948, and that I last saw him alive on November 7 1948.

Immediate cause of death CARDIAC FAILURE

Due to CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION

Due to ARTERIOSCLEROSIS, generalized

Other Conditions HYPERTROPHY OF THE PROSTATE GLAND

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

4 YEARS

8-10 YRS

MANY YEARS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin M Borden M. D.

Address 203 W. Fayette St Date signed 11/9/48

G68462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G68462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Patapsco Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY M WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-1629

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1877

8. AGE: Years	Months	Days	If less than one day
71	4	17	hr min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Car Shop Hand

FATHER
12. Name ? Wilson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Annie M. Torchia (niece)
(b) Address 3447 Woodstock Avenue (Tu. 6628)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 13 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co, Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. Balto. 30, Md.

19 (a) [illegible] 1948 (b) [illegible] Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948, at 7.30PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Ryan M.D.
Medical Examiner.
Date signed November 10, 1948

X

668463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

668463 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE FLORENCE CARRICK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W. Carrick, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years 72 | Months 5 | Days 21 22 | If less than one day hr. min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George W. Mellon
13. Birthplace: Baltimore County

MOTHER
14. Maiden Name: Beilemia Ritter
15. Birthplace: Baltimore County

16 (a) Informant: Mrs. Mary M. Davis
(b) Address: 1905 W. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive
Location: Randallstown Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Baltimore, Maryland

NOV 11 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15-2
(a) Date of injury 11-8-48 at ? A. M.
(b) Where did injury occur? 1905 W. North Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Fell down steps inside

23. Signature George W. Mellon M.D.
Medical Examiner.
Date signed 11-12-48

VS 151

668464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

668464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4203 Springdale Ave.

(c) Hospital or institution: Virginia Lee Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4300 Springdale Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGUERITE CONRAD CARR

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: B. Ashby Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 13, 1871

8. AGE: Years 77 | Months 9 | Days 26-27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: James Madison Monroe Conrad

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden Name: Mary Simms

MOTHER 15. Birthplace: Md.

16 (a) Informant: Miss Gladys Carr

(b) Address: 4300 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)

(c) Cemetery or crematory: Lorraine Park Cem.

Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 9:05p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 9 Nov. 1948 and that I last saw her alive on 5 Nov. 1948

Immediate cause of death: Bronchopneumonia — Duration: 4 days

Due to: Cerebral hemorrhage — 2 yrs.

Due to: General arteriosclerosis — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis E. Wice

Address 920 St. Paul St. Date signed 10 Nov. '48

668465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Raynes Ave. Dukeland St.
(b) Street address West Baltimore General Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 195 Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Sicki) Samuel Balser

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-8726

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1899

8. AGE: Years	Months	Days	If less than one day
48	11	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Self employed

11. Industry or business

FATHER
12. Name Raphael Balser
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Brenner
15. Birthplace Russia

16 (a) Informant Maurice Balser
(b) Address 3511 Forest Park Ave

17 (a) Burial (b) Date thereof Nov 12, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 11/11/48 for Arthur Williams M.D. Registrar
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 19 48 to 11/10 19 48.
and that I last saw him alive on 11/10 19 48.

Immediate cause of death Myocardial infarction — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Luther M.D.
Address West Balt Med Date signed Nov 12

Dup X

G68466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87c

G68466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry O. Elwiet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed~~, or ~~divorced~~.
Male	White	Married

6 (b) Name of husband or wife Catherine Elwiet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 13 1878

8. AGE: Years	Months	Days	If less than one day
70	—	27	hr. min.

9. Birthplace Home (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John G Elwiet
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret L. Giacomte
15. Birthplace Germany

16 (a) Informant Catherine Elwiet
(b) Address 215 S Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12 1948 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Lutheran
Location Biddle Road.

18 (a) Funeral director John G Rosan
(b) Address 3000 Baltimore St

19 (a) NOV 11 1948 (Date rec'd by registrar) Hampton Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1945 to Nov. 9 1948. and that I last saw him alive on Nov. 9 1948.

Immediate cause of death Paralysis Agitans — Duration 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Linden, M. D.
Address 14 S. Broadway Date signed 11/10/48

X

VS 150

668467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 668467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Glynn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR SCOTT HAINES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-01-4202

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	M

6 (b) Name of husband or wife Fannie E. Haines
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 20, 1867

8. AGE: Years	Months	Days	If less than one day
81	7	22	hr. min.

9 Birthplace Uniontown, Maryland
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Canton Bank

FATHER
12. Name John R. Haines
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Blackston
15. Birthplace Maryland

16 (a) Informant Kenneth B. Haines
(b) Address 2926 Riggs Avenue

17 (a) Burial (b) Date thereof 11/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Md.

18 (a) Funeral director Little's Funeral Home
(b) Address 2700 Edmondson Avenue

19 (a) NOV 11 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1948, at 5:20 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryze M.D.
Medical Examiner.
Date signed 11 Nov 48

VS 151

G68468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G68468 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME PETER CROCKETT SMITH

3 (b) If veteran, name war ?
3 (c) Social Security Account No. 579-14-5149

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Burke Smith
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) FEB. 8, 1895

8. AGE: Years 53 | Months 10 | Days 2 | If less than one day ##### min.

9. Birthplace Tylerton, Md. (Town, county, and state)
10. Usual Occupation Master, Tug Boat
11. Industry or business Harbor Towing Company

FATHER
12. Name Frank Smith
13. Birthplace Tylerton, Md.

MOTHER
14. Maiden Name Virginia Marshall
15. Birthplace Tylerton, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue, Balto. Co. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) (b) [illegible]
NOV 11 1948

V S 190

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 10 1948, at 12:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 10 1948, and that I last saw him alive on Nov. 10 1948.

Immediate cause of death Coronary thrombosis — Duration 1 hr

Due to generalized arterio-sclerotic disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 11/10/48

6d8169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

Registered No. 6d8169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Mosher Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ELLA ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1943

8. AGE: Years 5 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis H. Allen
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillian Smith
15. Birthplace Washington, D.C.

16 (a) Informan: Louis H. Allen
(b) Address 625 Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director GEORGE G. KELSON
(b) Address 1303 Presstman Street

NOV 11 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Ins. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd-3rd Burns
752 Body Surface

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-48 at 10:30 A.M.
(b) Where did injury occur? 625 Mosher Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Playing with matches; clothes afire

23. Signature Earl L. Kaye M.D.
Medical Examiner.
Date signed NOV 12 48

G68470 ✓ G68470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES STEPHEN ~~BRYSON~~ Bryson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Merle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1910

8. AGE: Years	Months	Days	If less than one day
38	2	9	hr. min.

9. Birthplace Frostburg, Maryland
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name James
13. Birthplace Frostburg, Maryland

MOTHER
14. Maiden Name Elizabeth McGreevy
15. Birthplace Frostburg, Maryland

16 (a) Informant Stein Funeral Home
(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Michael
Location Frostburg Md.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) (Entered) (Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 19 48 at 7:45 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kaye M.D.
Medical Examiner.
Date signed 11-11-48

151

G68471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Clifton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LONNIE ROBINSON

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/1894

8. AGE: Years 53 | Months 11 | Days 5 | If less than one day: hr. min.

9. Birthplace Raleigh, North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Rice
15. Birthplace N. C.

16 (a) Informant: Julia Robinson
(b) Address Tifton, Georgia

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory
Location Tifton, Ga.

18 (a) Funeral director Joseph E. Locks, Jr.
(b) Address 1342 Central Ave Huntington Williams, W. Va.

19 (a) NOV 11 1948 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948 at 12:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Uremia Arteriolitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D.
Date signed 11-10-48 Medical Examiner.

G68472

BC-40P-24962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 161a

G68472
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital - Caton & Wilkens Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Kinsey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY SCHEUERMANN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/10/48

8. AGE: Years	Months	Days	If less than one day
—	—	0	hr. 3 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John E.
13. Birthplace Balt Md.

MOTHER
14. Maiden Name ~~Mattie~~ ~~Grote~~ Alberta Kraft
15. Birthplace Balt Md.

16 (a) Informant Mr. John E Scheuermann
(b) Address 2752 Kinsey Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.11.48 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Balto. Md

18 (a) Funeral director Harry N. Witzke
(b) Address 4016 Edmondson Ave

19 (a) [illegible] Huntingtown Williams, Md
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 10 1948 and that I last saw h alive on Nov 10 1948

Immediate cause of death Respiratory failure — Duration

Due to congenital atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asa Maxwell M.D.
Address St Agnes Hosp Date signed 11/10/48

VS 150

G68473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G68473 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Howard
(c) City or town ELKRIDGE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** RUTH J HANCOCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1909

8. AGE: Years 39 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business BALTO. GAS & ELEC. CO

FATHER
12. Name RUFUS A HANCOCK
13. Birthplace VA

MOTHER
14. Maiden Name MINNIE ANN ROACH
15. Birthplace DELAWARE

16 (a) Informant MRS RUFUS A HANCOCK
(b) Address ELKRIDGE, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 13 '48 (month) (day) (year)
(c) Cemetery or crematory ST MARY
Location LAUREL, MD.

18 (a) Funeral director Harry H Wiltshe
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Nov. 10 1948 and that I last saw h-e alive on Nov. 10 1948

Immediate cause of death acute Hemorrhagic diathesis - generalized

Due to circulatory failure

Due to acute lymphatic leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John White M. D.

Address University Hosp. Date signed 10-10-48

X

G68474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G68474
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 E. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widower

6 (b) Name of husband or wife Rose Lee Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1865

8. AGE: Years	Months	Days	If less than one day
83	4	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Fireman

FATHER
12. Name William Hughes
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine —
15. Birthplace Baltimore

16 (a) Informant G. Lyle Hughes
(b) Address 1955 Sue St., N.W. Washington D.C.

17 (a) Burial (b) Date thereof 11-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) NOV 1 1948 (b) 6
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH November 10, 1948, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6, 1948, to Nov. 10, 1948, and that I last saw him alive on Nov. 10, 1948

Immediate cause of death Pulmonary Edema — Duration

Due to Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Ray E. Brown Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/10/48

VS 150

G68475 ✓ G68475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 KENYON AVE
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County .....
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 KENYON AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME JOHANNA GORCZEWICZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED.

6 (b) Name of husband or wife IZYDOR GORCZEWICZ
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) APRIL 13 1873

8. AGE: Years	Months	Days	If less than one day
75	6	26	..... hr. ..... min.

9. Birthplace POLAND. (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name MICHAEL WISNIEWSKI
13. Birthplace POLAND.

MOTHER
14. Maiden Name EVA ?
15 Birthplace POLAND.

16 (a) Informant MARY SWISKOWSKI
(b) Address 3000 KENYON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 12 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location GERMAN HILL ROAD

18 (a) Funeral director THE DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

NOV 11 1948 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 9 1948 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 4 1948 to NOV 9 1948, and that I last saw h alive on NOV 9 1948.

Immediate cause of death	Duration
Chronic nephritis —	4 days
Uraemia —	
Due to arterio-sclerosis —	
Due to	
Other Conditions Empty uterus	—

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumm M. D.
Address 722 No. Kenwood Ave. Date signed

NOV 10 1948

VS 189

G68476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G68476
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Huntingdon
(If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. NETTIE SCHOOLDEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife Mr. Adolph Schoolden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April 5, 1897

8. AGE: Years	Months	Days	If less than one day
51	7	4	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Daniel Palmer
13. Birthplace —

MOTHER
14. Maiden Name Carrie Myers
15. Birthplace —

16 (a) Informant (History from Record)
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Rd Balto Md

19 (a) NOV 12 1948 (Date rec'd by Registrar) (b) Huntington Williamson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1948, at 5 28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 9 1948, and that I last saw her alive on Nov 9 1948.

Immediate cause of death	Duration
Cardio-resp failure	48 hrs
Chronic congestive heart failure	
Due to Arterio sclerotic heart disease	
Due to	
Other Conditions Cerebral thrombosis, Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W. F. Cox M.D.
Address Union Memorial Hosp. Date signed 11-13-48

VS 150

X

G68477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G68477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important. correct age is

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton & Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3731 Garrison Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nellie Jeffery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1899

8. AGE: Years 49 | Months 1 | Days 15th | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Rudasill

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Baddy

15. Birthplace Virginia

16 (a) Informant Mr. Arthur Jeffery

(b) Address 3731 Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore County

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road Baltimore, Md.

19 (a) NOV 12 1948 (Date rec'd by Registrar) (b) Torrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 NOV 1948, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 NOV 1948 to 9 NOV 1948, and that I last saw HER alive on 9 NOV 1948.

	Duration
Immediate cause of death Cardio-respiratory failure, gastro intestinal bleeding	
Due to CARCINOMA of uterus with metastasis to Rt & Rt lumbar vertebra	
Due to	
Other Conditions SEVERE anemia MALNUTRITION	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rafael Ramsay M. D.

Address St. Agnes Hospital Date signed 9 NOV 1948

VS 150

X

668478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 668478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4031 Belle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4031 Belle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Oshry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kate Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1866

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Luna
15. Birthplace Russia

16 (a) Informant Morris Oshry
(b) Address 4031 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 2106 Eutaw Place

19 (a) Nov 12 1948 (Date received by registrar) (b) Registrar's signature Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-1948 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1948 to Nov 12 1948 and that I last saw her alive on Nov 12 1948

Immediate cause of death Cardiac decompensation — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro M. D.
Address 2028 Eutaw Pl Date signed 11/12/48

VS 150

G68479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G68479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cecelia Plott PLEET

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jacob
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Russia Lith (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Lith

MOTHER
14. Maiden Name Not Known
15. Birthplace Lith

16 (a) Informant Jack Pleet
(b) Address 4300 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. View Memory Lawn
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 NOV 12 1948 (Date rec'd by registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948 at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1948 to Nov 10 1948 and that I last saw her alive on Nov 10 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ray E. Parsons Jr. M.D.
Address St. Josephs Hospital Date signed 11/10/48

VS 150

68480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 68480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DRAWN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 Glyndon ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Glyndon ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Molly Anna Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	widow

6 (b) Name of husband or wife late Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1872

8. AGE: Years	Months	Days	If less than one day
76	3		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Grace Conway
(b) Address 1228 Glyndon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12 48 (month) (day) (year)
(c) Cemetery or crematory Emerald Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry A. Wittle
(b) Address 410 Edmondson ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntingtn Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/48 19 at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 8 1948 to 11/8/48 19, and that I last saw h[illegible] alive on 11/8/48 19.

Immediate cause of death	Duration
Bronchopneumonia	unknown
Due to Myocarditis	
Due to Uremia & Coma	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter T. Corbin M. D.
Address 410 Edmondson Date signed 11/10/48

VS 150

G68481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G68481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore, 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 E. Clement St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Elizabeth Harrington (HARRINGTON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Leo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/03

8. AGE: Years	Months	Days	If less than one day
45	8	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Schmidt
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Bates
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location 2 North Ave.

18 (a) Funeral director James L. McCaney
(b) Address 132 S. Fort Ave.

19 NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948 at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 10 1948 and that I last saw her alive on Nov 10 1948

Immediate cause of death	Duration
Acute pericarditis	
Due to Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Acute pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray C. Parsons Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/12/48

VS 150

G68382

BALTIMORE CITY HEALTH DEPARTMENT

LCH

CERTIFICATE OF DEATH

181

Registered No. G68382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Forest View Ave. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA MITCHELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 29, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	11 12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William T. Mitchell
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary A. Turner
15. Birthplace Delaware

16 (a) Informant Balto. City Hosp. Bertha & Alice Mitchell-4401 Forest View Ave.
(b) Address Baltimore City Hosp. Records 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 NOV 12 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10. 1948. at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/48 19 to 11/10/48 19, and that I last saw her alive on 11/10/48 19

Immediate cause of death 3rd Degree Burns of body

Duration 20 Hrs

Due to CERTIFICATION APPROVED BY Howard J. Madden, M.D.

Due to C. J. Fabrikant M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11.9.48 at 3 30 PM
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns from furnace

23. Signature C. J. Fabrikant M.D. M. D.
Address Balto City Hosp Date signed 11-11-48

VS 150

G68483

BALTIMORE CITY HEALTH DEPARTMENT

ES-94282

CERTIFICATE OF DEATH 131a

Registered No. G68483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Gilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fitzpatrick

3 (b) If veteran, name war WWI

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 30, 1865

8. AGE: Years	Months	Days	If less than one day
83	2	11	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Dudley
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Catholic
Location Baltimore, Md.

18 (a) Funeral director Milton C. Byrne
(b) Address 1424 Park Ave.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945 to 11-10 1948 and that I last saw him alive on 11-10 1948

Immediate cause of death Renal failure — Duration 1 week

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Reichold, M.D.
Address Balto City Hosp. Date signed 11-10-48

68384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 526

Registered No. 68384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5507 Bland ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 Bland ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Francis A. Westrich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or wife Alice R.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 11-24-1870

8. AGE: Years 77 | Months 11 | Days 17 | If less than one day: hr. ____ min. ____

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Westrich
13. Birthplace Ohio

MOTHER
14. Maiden Name Catherine Berkamp
15. Birthplace Unknown

16 (a) Informant Mrs. Alice R. Westrich
(b) Address 5507 Bland Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948 at 5A M

21. I certify that death occurred on the date above stated, that I attended deceased from April 2 1948 to Nov 11 1948 and that I last saw h[illegible] alive on Oct 1 1948.

Immediate cause of death	Duration
Carcinoma Urinary bladder	7 mo.
Due to Uremic Coma	3 days
Due to Suppression of Urine	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 1948

Major findings of operation Malignancy of the bladder

of autopsy: [illegible]

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman R. Draper M. D.
Address 2001 Manhattan St. Date signed 11/14/48

VS 150

G68485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68485

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Cresmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Cresmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE A. SICKEL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George H. Sickel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 19, 1872

8. AGE: Years: 76 | Months: 5 | Days: 22 23 | If less than one day: hr min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Wilson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary --
15. Birthplace: Unknown

16 (a) Informant: Mrs. C. F. Butcher
(b) Address: 103 Franklin Ave., Silver Spring Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/48 19 ~~50~~ M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ware M.D.
Medical Examiner.
Date signed 11/12/48

VS 151

668386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668386 Registered No.

8 2a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Walkers + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 29 (If outside city or town limits write RURAL, and give town)

(d) Street No. 606 Woodington Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Virginia H. Gale.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-1196

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas W. Gale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-07

8. AGE: Years 41 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Kent Co.) (Town, county and state)

10. Usual Occupation School teacher

11. Industry or business Dept. Edu. Balto. City

FATHER 12. Name James Wood dec.

13. Birthplace Md.

MOTHER 14. Maiden Name Nellie Sappington

15. Birthplace Md.

16 (a) Informant Mr. Thomas W. Gale

(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel Cem.

Location Rock Hall, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1948 8:10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-9 48, to 11-11 48, and that I last saw h alive on 11-11 48

Immediate cause of death (a) Respiratory failure

Due to (b) Cerebral Hemorrhage.

Due to (c) Hypertension

Other Conditions

(Include pregnancy within three months of death)

Duration 2 days.

Date of operation 11/11/48

Major findings of operation: Cerebral Hemorrhage - left temporal

Findings of autopsy: Hemorrhage left temporal

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos. W. Gale

Address 606 Woodington Rd. Date signed M D 11/14/48

VS 150

68187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

Registered No. 68187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Mount Holly Street
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Mount Holly St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Peter N. Margaritis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
60 yrs				

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER
12. Name Nick Margaritis
13. Birthplace Turkey

MOTHER
14. Maiden Name Sophia
15. Birthplace

16 (a) Informant James Margaritis
(b) Address 1000 Mount Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lambros F.H. Inc
(b) Address 438-40 E. North ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948, at 3 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to Nov 1948, and that I last saw him alive on Nov. 9 1948

Immediate cause of death: Cardiac failure — Duration

Due to Bronchial - Carcinoma asthma

Due to Bronchiectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: /

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2301 Kirkwood Pl. Date signed

VS 150

G68488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G68488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Simmons Anderson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widow

6 (b) Name of husband or wife Raymond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 6, 1891

8. AGE: Years	Months	Days	If less than one day
57	-	4	hr. min.

9. Birthplace Bees Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Anderson Simmons
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Savage
15. Birthplace Va.

16 (a) Informant Charles Earl Anderson
(b) Address 1902 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mr. Robt. G. Elliott, Dagsby
(b) Address 1129 N. Carlton St

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10, 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/47 to 11/10/48; and that I last saw h[illegible] alive on 11/10/48.

Immediate cause of death: Carcinoma of Ovary — Duration

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Rochlitz M.D.
Address 412 N. Gilmor St (Date signed 11/12/48)

VS 133

G68489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13-a

G68489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Rectory Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Rectory Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	24	3 hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna Baker
15. Birthplace Pennsylvania

16 (a) Informant Mr. Roland Howard
(b) Address 1012 Rectory Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road Balto. Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) Interment

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1948 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 10 1948, and that I last saw her alive on Nov. 10 1948

Immediate cause of death: Coronary Occlusion — Duration: 1 day

Due to Cardio-renal-vascular Disease

Due to CERTIFICATION APPROVED BY Howard J. Madden, M.D.

Other Conditions C. J. Lubinski M.D. CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M.D.
Address 617 W. 40th St. Date signed 11/10/48

VS 150

C68490 Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C68490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 E. West St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosemary Pyle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife William G. Pyle 6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr) 2/7/1856

8. AGE: Years	Months	Days	If less than one day
92	9	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hagman Rudolph

13. Birthplace Germany

MOTHER 14. Maiden Name Rosemary McNaughton

15. Birthplace Ireland

16 (a) Informant Mr Francis Pyle

(b) Address 32 E. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 1218 Light St

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/48 19 . at 11:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/20/48 to 11/11/48 and that I last saw h alive on 11/11/48.

Immediate cause of death Coronary thrombosis — Duration 1 day

Due to Arteriosclerosis

Due to Senility — Duration assumed 1 day

Other Conditions Osteoporosis with fracture of left femur — Duration 3 days

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED

Major findings of operation:

of autopsy: Howard J. Madison
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Oct 19 1948 at ? M

(c) Where did injury occur? Home
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? Kitchen
(Specify type of place)

(e) Means of injury Fell through old floor in

23. Signature Isaac Miller M.D. M. D.

Address 1225 Cleveland St Date signed 11/11/48

VS 150

G68491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G68491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th St.

(c) Hospital or institution: Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Sula Norris Hooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband ~~or wife~~ Thomas D. Hooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	4	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife formerly.

11. Industry or business None

FATHER 12. Name John C. Norris

13. Birthplace Lancaster Co., Va

MOTHER 14. Maiden Name Susan D. Rogers

15. Birthplace Baltimore Co., Md.

16 (a) Informant Home for Incurable Records-M.F.O.

(b) Address 700 W. 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director Stewart & Madden Co.

(b) Address 101 W. North Av. - City

19 NOV 12 1948 (b) [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1940, to 11/12 1948, and that I last saw him alive on 11/11 1948.

Immediate cause of death Generalized Abdominal Carcinomatosis ? — Duration 6 months

Due to

Due to over

Other Conditions Arthritis Deformans — 12 years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(c) Means of injury

23. Signature W. Grafton Hershberger M. D.

Address 214 Medical Arts Bldg Date signed 11/12/48

VS 150

068492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

068492 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309-E-North Ave
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2) USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 E North Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME Eugene Ludwig Renner

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Divorced

6 (b) Name of husband or wife: Mary E. Wengert
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 23 1871

8. AGE: Years 77 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business none

FATHER
12. Name Geo. P. Renner
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Suring
15. Birthplace on Atlantic Ocean

16 (a) Informant Mr. C. J. L. Renner (Bro.)
(b) Address 309 E North

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Stuart Morris Co.
(b) Address 108 W North Ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10th 1948, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947, to Nov. 10th 1948, and that I last saw h/m. alive on Nov. 10 1948.

Immediate cause of death: Myocarditis — Duration: Several years
Due to:
Due to: Arteriosclerosis — Duration: Unknown
Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ferdinand L. Ries D
Address 24 S. Broadway Date signed 11/10/48

VS 3

68393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES BIDDLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Sadie Biddle (dec'd)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1875

8. AGE: Years	Months	Days	If less than one day
73	4	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Biddle
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Jennett Sorrell
15. Birthplace Baltimore, Maryland

16 (a) Informant Clarence Biddle
(b) Address 615 W. Barre Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 15/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) NOV 12 1948 (Must be filed by registrar) **(b)** Huntingtown Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Jubenville M.D.
Medical Examiner.
Date signed 11/11/48

VS 151

X

G68494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68494 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Sts
(c) Hospital or institution: Univ. Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Seidell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Walter Eigner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Cassandra Eigner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 20, 1888

8. AGE: Years	Months	Days	If less than one day
60	2	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Jacob Eigner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hottes
15. Birthplace Maryland

16 (a) Informant Gladys A. Eigner
(b) Address 4311 Seidell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John A. Mozar
(b) Address 3000 E. Balt. St.

19 NOV 12 1945 (Date rec'd by registrar) (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 11-13 1945.
and that I last saw him alive on 11-10 1945

Immediate cause of death	Duration
pulmonary embolism.	
a coronary thrombosis	
Due to — Rt Side hemiplegia	
arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E. Tull M. D.
Address Blue Ridge Summit Date signed 11-10-45

VS 150

G68195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G68195
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine Fell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Henry Fell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 17, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	25	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Barnat Etzel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ? ?
15. Birthplace Germany

16 (a) Informant Henry Fell
(b) Address 2817 Clifton Ave

17 (a) Burial (b) Date thereof 11-15-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Balt. St.

19 (a) NOV 12 1948 Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 11/10 1948 and that I last saw her alive on 11/10 1948.

Immediate cause of death
Carcinoma of stomach with obstruction — Duration

Due to General carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/22/48

Major findings of operation: Carcinoma of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A L Hornstein
Address 704 E. Biddle St Date signed 11/13/48

VS 150

668496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120

Registered No. 668496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Conkling Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Stanton Daggert Hughes JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-24-3309

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 6, 1928.

8. AGE: Years	Months	Days	If less than one day hr.	min.
20	6	4		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Works for Crocker Union

FATHER
12. Name Stanton D. Hughes Sr.
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Minnie Shorty.
15. Birthplace Balto Co., Md.

16 (a) Informant Stanton D. Hughes Sr.
(b) Address 918 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7225 Eastern Ave

18 (a) Funeral director Charles S. Leiter
(b) Address 901 S. Conkling St.

19 (a) Nov 12 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30/ 1948 to 11/10/ 1948, and that I last saw him alive on 11/10/ 1948.

Immediate cause of death Uremia — Duration

Due to Subacute Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Roy E. Parsons Jr. M.D.
Address 1 E. Chase St. Date signed 11/10/48

VS 150

G68197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G68197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Springdale Ave.
(c) Hospital or institution:
Virginia Lewis Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Julia Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Cecil Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
70	-	16	hr. min.

9. Birthplace Cedar Falls, Iowa
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Theodore Imhoff
13. Birthplace Canton, Ohio

MOTHER
14. Maiden Name Julia Higgins
15. Birthplace Lexington, Kentucky

16 (a) Informant Mr. Percy T. Shaw
(b) Address 4608 Weddon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director T. Willis Lamsman
(b) Address 4510 Liberty Heights Ave.

19 (a) Nov 1 1948 (b) Tunstington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Nov 1 1948.
and that I last saw h[illegible] alive on Nov. 2 1948

Immediate cause of death: Carcinoma of Pleura — Duration: 6 mos.

Due to: Carcinoma of Breast

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1942

Major findings of operation: Ca of Breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Lamsman M. D.
Address [illegible] St. Paul St. Date signed 11-2-48

VS 100

668498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 668498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3863 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3863 Forest Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May M. Tregor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John D. Tregor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Vincent Ramey
13. Birthplace Germany

MOTHER
14. Maiden Name Vein
15. Birthplace Germany

16 (a) Informant Miss Miriam Schmidt
(b) Address 4019 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1949 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Ellis Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) Nov 12 1949 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1949 at P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 16 1942 to Nov. 10, 1949 and that I last saw her alive on Nov. 10, 1949

Immediate cause of death	Duration
Coronary Thrombosis	½ hr.
Coronary Arteriosclerosis	20 months
Due to Hypertensive Cardio-Vascular Disease	?
Due to Generalized Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 5401 N. Port Ave. Date signed 11/11/49

VS 150

X

668199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668199 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3639 Poland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3639 Poland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Pinker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower.

6 (b) Name of husband or wife: Fannie M. Pinker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1874

8. AGE: Years	Months	Days	If less than one day
74	9	16	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Painting
11. Industry or business

FATHER
12. Name George Pinker.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Elizabeth Jeanbroad
15. Birthplace Virginia

16 (a) Informant Mr. Parker Pinker.
(b) Address 3639 Poland ave

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov 15/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Austin E. Donovan
(b) Address 3638 Poland Ave

19 (Date received by local registrar) Nov 12 1948 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1948 at 3 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1948 to 11/11 1948 and that I last saw h[illegible] alive on 11/11 1948

Immediate cause of death Cerebral Hem
Hemiplegia
Duration 24 hrs

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 2020 N. Charles Date signed 11/12/48

VS 150

668500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92c

668500

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 Gerland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine MacCubbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 24 1888

8. AGE: Years 60 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John G. Niedersphan
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Blotkamp
15. Birthplace Md

16 (a) Informant Mrs. Robert MacCubbin
(b) Address 5406 Gerland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Rd

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Interment or Removal Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1948, at 5 15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/2 1948, to 11/12 1948, and that I last saw her alive on 11/12 1948.

Immediate cause of death: Rheumatic toxic Stenosis
Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic toxic Stenosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie Okeson, M.D. M. D.
Address Sinai Hosp. Baltimore Date signed 11/12/48

VS 150

Dr. Speed
11 E. Chase Street

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. 68501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 West Franklin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 West Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Langrill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry J. Langrill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 18, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	22	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Mac Cormack
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Smyth
15 Birthplace Ireland

16 (a) Informant Mrs. Frederick Bach
(b) Address 540 Winston Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-348 (month) (day) (year)
(c) Cemetery or crematory New Cathdral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 9 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to November 9 48.
and that I last saw h alive on 11/9 1948.

Immediate cause of death	Duration
Acute pulmonary edema	
Due to Bilateral, bronchopneumonia	
Due to Rheumatic heart disease	
Other Conditions Atrophic arthritis, Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Speed M.D.
Address 11 E. Chase St. Date signed 11/10/48

VS 159

668502

Dr. Grossfeld
3402 Belair

668502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 668502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence M. Cier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Andrew W. Cier
6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr): Apr. 21, 1884

8. AGE: Years: 64 | Months: 6 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: ? Dittlemar
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mr. Andrew Cier
(b) Address: 3105 White Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road #14

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 - 1948, to Nov. 11 1948; and that I last saw h[illegible] alive on Nov. 11 1948.

Immediate cause of death: Cerebral Hemmorhage — Duration: 5 days

Due to: C.V.D. decr'd 3 yrs

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature: Michael J. Grossfeld, M.D.
Address: 5407 Belair Date signed 11-11-48

VS 150

G68503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Schley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frederick G. Gibmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M.

6 (b) Name of husband or wife Mrs. Dorothy Gibmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25-1908

8. AGE: Years	Months	Days	If less than one day
40	2	18	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Bethl Steel Co.
FATHER 12. Name Wm. Gibmeyer
13. Birthplace Md.
MOTHER 14. Maiden Name Rose
15. Birthplace Md
16 (a) Informant Mrs. Dorothy Gibmeyer
(b) Address 4701 Schley Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director Leonard J. Luck
(b) Address 5301 Harford Rd.
NOV 12 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/48 19 . at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948, to 11/12 1948, and that I last saw him alive on 11/11 1948.

Immediate cause of death	Duration
Sub-Arachnoid Hemorrhage (Spontaneous)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William S. Womack M D
Address Bon Secours Hosp. Date signed 11/12/48

VS 150

68504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 68504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem Steel-Sparrows Pt. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Lombard Street (West) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN KARL KEEHNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 28, 1908

8. AGE: Years	Months	Days	If less than one day
40	3	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Bethlehem Steel Company

FATHER
12. Name Daniel H. Keehner
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth M. Meyer
15. Birthplace Germany

16 (a) Informant Mary J. Medinger
(b) Address 2416 W. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Maryland

18 (a) Funeral director George L. Ackenheil
(b) Address 2101 Pitcairn Ave

19 (a) NOV 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948 at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogow M.D. (Medical Examiner)
Date signed 11-12-48

VS 181

G68505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 20 days

(e) Length of stay in Baltimore (yrs., mos., or days): 20 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Me. (b) County: Saco

(c) City or town: (If outside city or town limits, write RURAL and give town)

(d) Street No.: Tasker St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: ALBERT CHARLES GRACE

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	yes- ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1927

8. AGE: Years	Months	Days	If less than one day
21	8	15	hr. min.

9. Birthplace: NY (Town, county, and state)

10. Usual Occupation: Messman

11. Industry or business: Seafarer

FATHER

12. Name: Walter Grace

13. Birthplace: Me.

MOTHER

14. Maiden Name: Sophie Fritzbung

15. Birthplace: Pa.

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16-48 (month) (day) (year)

(c) Cemetery or crematory: Saint Mary's

Location: Biddeford Maine

18 (a) Funeral director: E Haworth Armistead

(b) Address: 3911 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Transit or Burial Permit Issued by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948 to Nov. 12 1948 and that I last saw him alive on Nov. 12 1948.

Immediate cause of death	Duration
Hodgkins Disease	
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: James B Dukes, M. D.

Address: U S Marine Hosp Date signed: 11/12/48

668506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92E

Registered No. 668506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Abell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH R. KEENE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Adelia Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1858

8. AGE: Years	Months	Days	If less than one day
90	9	12	hr. min.

9. Birthplace Madison, Dorchester Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter, Retired
11. Industry or business

FATHER
12. Name Josiah Keene
13. Birthplace Md

MOTHER
14. Maiden Name Freces Frazier
15 Birthplace Md

16 (a) Informant Mrs. Herbert Ireland
(b) Address 3129 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Church Creek Episcopal
Location Dorchester Co., Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19. (a) NOV 13 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Nov 11 1948. and that I last saw h alive on Nov 11 1948.

Immediate cause of death Myocarditis

Due to

Due to Cerebral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature John F. Oliver M. D.
Address 612 N 40 St Date signed

VS 150

68507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Beachwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BRICE E. WALTON, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1929

8. AGE: Years	Months	Days	If less than one day
19	7	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business C. A. Walton

FATHER
12. Name Brice E. Walton
13. Birthplace Virginia

MOTHER
14. Maiden Name Maude V. Shiflette
15. Birthplace Virginia

16 (a) Informant Burnes Walton
(b) Address 1512 Stengel Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Charlottsville, Virginia

18 (a) Funeral director ROLAND L. FISHER
(b) Address 5112 Dundalk Ave

19 (a) NOV 13 1948 Huntington Williams, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Intra Cranial Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at 12:25 P. M.
(b) Where did injury occur? New N. Point Rd. & Wise Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Motorcycle and Bus Collision

23. Signature Emil Beyl M.D.
Medical Examiner
Date signed 11-12-48

VS 181

G68508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G68508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Key Highway--American Sugar
(c) Hospital or institution: Refinery

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERNEST (SUMMERFIELD) SOMMERFIELD

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 350-05-7702

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	M	Married

6 (b) Name of husband or wife: Augusta

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) November 15, 1891

8. AGE: Years	Months	Days	If less than one day
(D.M.) 56	11	28	hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Maritime Guard

11. Industry or business: Long Shoremans Union

FATHER
12. Name: Frank Sommerfield
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta Locach
15. Birthplace: Germany

16 (a) Informant: Augusta Sommerfield
(b) Address: 111 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-1948 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Md

18 (a) Funeral director: Pratt C. Walters
(b) Address: Pratt & Stricker Sts

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 19 48 at 12:15 P. M.

21. I certify that I took charge of the remains described above, held an Insp. & Ind. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Edema

Due to: Acute congestive heart failure

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Earl L Royer M.D.
Medical Examiner.

Date signed 11/12/48

VS 151

668509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Bridgeview Road
(c) Hospital or institution: Residence
(d) Length of stay in hospital or inst. (yrs., mos., or days) none.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs +.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County City
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 West Franklin St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Jackson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Fleming Jackson Deceased 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 1775 [illegible]
8. AGE: Years 73 Months 2 Days 2 If less than one day hr. 2 min.
9. Birthplace Lancaster County, VA (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name ? —
13. Birthplace —

MOTHER
14. Maiden Name Felisciah Williams
15. Birthplace Lancaster County, VA.

16 (a) Informant Mrs Julia Miller
(b) Address 923 West Franklin St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director A. Halgrand & Sons
(b) Address 916 E. Lanvale St.
19 (a) NOV 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 12 1948 at 9:10 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Called to Pronounce Dead 19 to 19 .
and that I last saw h — alive on — 19 —.
Immediate cause of death Cardiac Failure
Due to Senility
Due to
Other Conditions Arterio Sclerotic Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jerry E. Luck, M.D. M.D.
Address 303 Bridgeview Date signed 11-12-48

VS 150

162 R

66851.0

M M.- 122411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

✓ 66851.0 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTOMORE CITY HOSPTIALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 LLEWELYN AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMANUEL WADE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1900

8. AGE: Years	Months	Days	If less than one day
48yrs.	5	2	hr min

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name RALPH WADE.
13. Birthplace MD.

MOTHER
14. Maiden Name MATILDA GROSS.
15. Birthplace MD.

16 (a) Informant BALTO. CITY HOSP. RECORDS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)

(c) Cemetery or crematory MD. Calvary
Location A. Halstead

18 (a) Funeral director 918 Light Street
(b) Address

19 (a) NOV 12 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 at 330 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25/48 19 to 11/10/48 19 and that I last saw him alive on 11/10/48 19

Immediate cause of death: Respiratory failure — Duration: 4-5yrs.

Due to: Pulmonary tuberculosis

Due to:

Other Conditions: Carcinoma of colon
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm. tbc + Ca of colon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause(s), fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gayle Burton M.D.
Address Baltimore City Hospitals Date signed 11/11/48

VS 150

12E

668511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

668511 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317- Madeira Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317- Madeira Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha McRae

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) ? ? 1882

8. AGE: Years 66 | Months | Days | If less than one day hr min

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business ?

FATHER 12. Name George ?
13. Birthplace N. C.

MOTHER 14. Maiden Name Lecle
15. Birthplace N. C.

16 (a) Informant Sarah Ingram
(b) Address 1048- Argyle Ave

17 (a) Disposition Sheppard Date thereof (burial, cremation, or removal) 11-13-48 (month) (day) (yr.)
(b) Cemetery or crematory Wadesboro, N. C.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Edmondson Ave

19 (a) Nov 13 1948 (b) Registrar
(Signature of City Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-1948 hr M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1948, to Nov. 1948, and that I last saw her alive on 11-8 1948

Immediate cause of death Chronic endocarditis

Duration

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell
Address 118 Dolphin St. Date signed 3 - 1948 M. D.

925

668512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. 668512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (REV.) SAMUEL DEWEY WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1904

8. AGE: Years	Months	Days	If less than one day
44	5	10	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Samuel Washington
13. Birthplace Lemont, Pa.

MOTHER
14. Maiden Name Belle Mahone
15. Birthplace Virginia

16 (a) Informant Mrs. Evelyn Washington
(b) Address 1819 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1948 at 8:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948 to 11-9 1948.
and that I last saw him alive on 11-9 1948

Immediate cause of death: Cerebral Hemmorhage
Agut Stroke
Due to Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Wilbur Phillips M.D.
Address 1543 Penna Ave Date signed 11-11 48

VS 153

668513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

668513 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1238 Etting Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst., (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1238 Etting Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HENRY HARRIS JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mathilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1872

8. AGE: Years 76 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace Ellicott City, Maryland (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER

12. Name William H. Harris

13. Birthplace Maryland

MOTHER

14. Maiden Name Miranda Miller

15. Birthplace Maryland

16 (a) Informant Mrs. Mathilda Harris

(b) Address 1238 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1948 at 9:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 7-10 1948 to 11-11 1948 and that I last saw h alive on 11-11 1948

Immediate cause of death — Duration

Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. D.

Address 561 Date signed 11-12-48

VS 153

The 68514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 168514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Druid Hill Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (REV.) JULIUS CAESAR PAROLA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Mildred Parola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1885

8. AGE: Years: 62 | Months: 10 | Days: 15 16 | If less than one day: hr. min.

9. Birthplace: British West Indies (Town, county, and state)

10. Usual Occupation: Minister

11. Industry or business

FATHER
12. Name: Julius C. Parola
13. Birthplace: British West Indies

MOTHER
14. Maiden Name: Uknown
15. Birthplace

16 (a) Informant: Ella Mildred Parola
(b) Address: 2202 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1948, at 5 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1928 1948 to 11/10 1948, and that I last saw him alive on 11/10 1948

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 74 Dunham Rd. Date signed 11/14/48

VS 150

668515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 Underwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Underwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP M. OSBORNE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harriet Jarvis Osborne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1901

8. AGE: Years 47 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Madison Lodge, Kan. (Town, county, and state)
10. Usual Occupation Certified Public Accountant
11. Industry or business

FATHER
12. Name George Osborne
13. Birthplace Kansas, Missouri

MOTHER
14. Maiden Name Nena C. Crawford
15. Birthplace Missouri

16 (a) Informant Mrs. Harriet Jarvis
(b) Address 5107 Underwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1948 (Date received by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17th 1942 to Nov. 11th 1948, and that I last saw him alive on Nov. 11th 1948.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 yrs.
Due to Coronary Insufficiency — Duration: 6 yrs.
Due to Coronary occlusion — Duration:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Greenler M. D.
Address 817 Medical Arts Bldg. Date signed 11.12.48

VS 150

668516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668516 Registered No. 12R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Dryden Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Dryden Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MAY SEDBERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Osoar L. Sedberry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Sept. 3, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	9	hr. min.

9. Birthplace Green Castle, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Rush Crunkleton
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Margaret Barnhart
15. Birthplace Pa.

16 (a) Informant Mr. R. Archie Phebus
(b) Address 708 Dryden Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 12 1948 (b) (Registrar's local registered number) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1948 to Nov 11 1948 and that I last saw h- alive on Nov 11 1948

Immediate cause of death Pulmonary Tuberculosis — Duration 2 Yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dewey O Russell
Address 3902 Woodland Ave Date signed 11/12/48

G68517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No. G68517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Marylend
(b) Street address 822 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) **FULL NAME** James A. Slaysman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Bailey Slaysman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 13, 1885
8. AGE: Years 62 | Months 10 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Car Repairman
11. Industry or business at B & O. R.R. Shops.

FATHER
12. Name Alexander Slaysman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary McCluskey
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Elizabeth Slaysman
(b) Address 822 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4302 Ed Frederick Rd

18 (a) Funeral director Edwin W. Coghlan
(b) Address 924 E. Eager St.

19 (a) NOV 13 1948 (Date received by registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Nov 12 1948. and that I last saw him alive on Nov 12 1948

Immediate cause of death: Carcinoma Left Lung — Duration: 7 months
Due to:
Due to:
Other Conditions: Carcinomatosis — 2 months
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hart M. D.
Address 1631 E. North Ave Date signed 11/12/48

V S 150

668518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72B

Registered No. 668518

668518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: So Balto. Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) ~~Balto~~ Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1308 Sargeant St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** William J. Wheeler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Helen L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 5th 1904

8. AGE: Years 44 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Plumber Inspector

11. Industry or business Baltimore City

FATHER 12. Name William J. Wheeler

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary Welsh

MOTHER 15. Birthplace Ireland

16 (a) Informant Mrs Helen L. Wheeler

(b) Address 1308 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3801 Frederick Ave

18 (a) Funeral director John J. Lowman & Son

(b) Address 901-03 Hollins St.

19 (a) NOV 13 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 2.50 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 11, 1948 to Nov. 12 1948 and that I last saw him alive on Nov. 12, 1948.

Immediate cause of death	Duration
Hemorrhagic Diathesis	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Massive hemorrhage GI tract

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Marion C. Braley, Jr. M.D.

Address So. Balto. Gen Hosp Date signed 11/14/48

668519

BALTIMORE CITY HEALTH DEPARTMENT

AUMON CERTIFICATE OF DEATH 46

668519
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Gwynn's Falls Pky.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A Aumon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Lucy C. Aumon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 20, 1869

8. AGE: Years	Months	Days	If less than one day
79	6	21	hr. min.

9. Birthplace Hanover Pa.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Penna.

MOTHER
14. Maiden Name King
15. Birthplace Penna.

16 (a) Informant Mr. Milton L. Aumon
(b) Address 2500 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1900 West North Ave.

19 (a) NOV 19 1948 (b) Huntington Williams Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Novemb 6 48 to Nov 11 1948, and that I last saw him alive on 11 - 11 - 1948.

Immediate cause of death carcinoma of rectum

Due to terminal stage of carcinoma of rectum

Due to

Other Conditions Hypertensive CVD

(Include pregnancy within 3 months of death)

Date of operation 10 - 13 - 48

Major findings of operation: Carcinoma of rectum

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes; fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Rosser M.D.
Address University Hosp. Date signed 11-11-48

VS 150

G68520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G68520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1803 Thornbury Rd.

(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1808 Park Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES W. HARRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth E. Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1870

8. AGE: Years	Months	Days	If less than one day:
78	7	23	4 hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name David G. Harry
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Maria Warner
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Elizabeth E. Harry
(b) Address 1808 Park Ave.

17 (a) Cremation (b) Date thereof 11/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 11/13 1948.
and that I last saw him alive on 11/13 1948.

Immediate cause of death: Generalized arterial sclerosis.

Duration: 7

Due to

Due to

Other Conditions: Bronchostasis
Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George W. Armistead Jr. M. D.

Address 114 St. Paul St. Date signed 11/13/48

VS 150

668521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(92)

Registered No. 668521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp - 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give county)
(d) Street No. 105 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Limerick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Feb. 3, 1878

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1878

8. AGE: Years 70 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business Mor - Sinclair & Scott

FATHER
12. Name ? ?
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name ? ?
15. Birthplace Balto., Md.

16 (a) Informant Robt. V. Limerick (Son)
(b) Address 23 E. Front Ave., Balto 39 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon., Nov. 15, 1948 (month, day, year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 E. Pleasant St. (30) Huntington Williams, M.D.

NOV 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Nov. 1948 at 8:21 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Hypertensive Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, M.D. Medical Examiner.
Date signed 11 Nov. 48

VS 151

668522 HUBER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 668522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Cypress St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or day's)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Cypress Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lana L. Huber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1877

8. AGE: Years	Months	Days	If less than one day
71	8	3	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Taube
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant: Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Ave.

19 NOV 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Nov. 1948, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, M.D. Medical Examiner.
Date signed 12 Nov. 48

VS 151

668523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 668523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Valley St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Margaret Mary Zeigler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. H. Zeigler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	19	12 hr. min.

9. Birthplace Irelaand (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Retican
13. Birthplace Irelaand

MOTHER
14. Maiden Name Bridget Kelly
15. Birthplace Ireland

16 (a) Informant Mr. Zeigler
(b) Address 1307 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rite Wiedefeld
(b) Address 900 East Biddle St

19 NOV 13 1948 (b) Huntington Volunteer, Md. Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Nov 1948, at 4:04 M

21. I certify that death occurred on the date above stated, that I attended deceased from — 1937 to 12 Nov 1948, and that I last saw h alive on 11 Nov 1948

Immediate cause of death: Anemia — Duration: 5 days

Due to Cystic-transuden - renal [illegible] hypertension + arteriosclerosis — ? ?

Due to Diabetes — 4 years 10 yrs.

Other Conditions: Gangrene L left. heel
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Samuel Zeigler M.D.
Address 714 E. Preston Date signed 13 Nov 48

VS 150

668524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

668524

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Roche

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	10	14		

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name No Lindsay
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Little Sister of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wendfeld
(b) Address 900 East Biddle St

19 Nov 13 1948 (b) Huntington Williamson, M.D. (Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Nov 12 1948, and that I last saw h[illegible] alive on Nov 11 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature E. Gill Frat
Address 163 E Van St Date signed Nov 12 48

VS 150

G68525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G68525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution:
Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 6 11
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 84

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 John St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Mary Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1865 ~~Not Known~~

8. AGE: Years	Months	Days	If less than one day
83	7	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edmund H. Brewer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia (Not Known)
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thomas L. Berry
(b) Address 12 Pine Drive Towson 4 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Wm Oakley Inc.
(b) Address 1217 St Paul St

NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 13 1948, and that I last saw her alive on Nov 12 1948.

Immediate cause of death Cerebrovascular accident — Duration ~~of illness~~

Due to Hypertensive Cardio vascular disease

Due to

Other Conditions Pneumonia, left lower lobe

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia, an abscess.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark E. Hall Jr. M. D.
Address Hosp. for Women of Md Date signed 11/13/48

VS 150

G68526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G68526
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE C. COOPER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 66 | Months: | Days: | If less than one day: hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (Unknown) Baker
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Frank L. Fisher
(b) Address 704 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 . at 8:30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 48 to 19 48 and that I last saw her alive on 11 Nov 19 48

Immediate cause of death: Carcinoma of breast with metastasis — Duration: 3 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Jay M Zimmerman
Address 2050 Linwood Ave. Date signed 13 Nov. 48 M D

VS 150

W-25 668527 668527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby-Boy Nowacki

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-11-48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Nowacki
13. Birthplace Md.

MOTHER 14. Maiden Name Marie Rutkowski
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 14 1948 (month) (day) (year)
(c) Cemetery or crematory ST STANISLAUS
Location DUNDALK AVE

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 LOMBARD ST.

NOV 14 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 13 1948 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-1948 to 11-13-1948 and that I last saw h[illegible] alive on 11-13-1948

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. O. Goldstein

Address Johns Hopkins Hosp. Date signed 11/13/48 (M/D)

668528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 668528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner ave + Dukeland st.

(c) Hospital or institution West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-7-21

(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:

(d) State Maryland (c) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3615 Lucille Ave. (If rural give location)

(e) Citizen of foreign country? Russia (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Annie Zeskind

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	## W

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years	Months	Days	If less than one day hr.	min.
71				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Henry

13. Birthplace Russia

MOTHER

14. Maiden Name Henna Fagn

15. Birthplace Russia

16 (a) Informant Louis Zeskind

(b) Address 3112 Garfield St NW Wash DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men Location Woodlawn Milk Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 1660 Eutaw Place

19 (a) [illegible] (b) [illegible] (Date received by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948, at 1 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948 to 11/13 1948. and that I last saw her alive on 11/13 1948

Immediate cause of death Cerebral vascular accident — Duration

Due to Hypertensive Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Blunt Trauma MD

23. Signature West Baltimore General Hosp

Address Date signed Nov. 19, 1948

G68529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Govn't Emb. Hosp
(c) Hospital or institution: Govn. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Beechgrovville Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Marie Boring

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F	W	Married

6 (b) Name of husband or wife Sidney C Boring
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) Unknown

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business own home

FATHER
12. Name Littleton P Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence L Henry
15. Birthplace Virginia

16 (a) Informant Sidney C Boring
(b) Address Brentwood Md. R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 16 48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) Filed NOV 14 1948 (b) Registrar Wellington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1948 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948 to 11-13 1948, and that I last saw him alive on 11-13 1948

Immediate cause of death
Intussusception
Due to Phlebitis left leg
Due to Sarcoma of stomach — intussusception obstruction
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard C Hall M.D.
Address Govn. Hosp Date signed 11-13 1948

VS 153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68530 ✓ G68530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE DeCOURSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 29, 1897

8. AGE: 51 Years | 4 Months | 12 Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Columbus DeCoursey
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Celeste Saxton
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Miss Mary DeCourcey
(b) Address 2011 McCulloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 14 1948 (Date received by registrar) (Signature of registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948 at 3:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 11 1948.
and that I last saw h alive on Nov 11 1948

Immediate cause of death: Chronic Glomerular Nephritis — Duration: Couple years

Due to: Uremia

Due to:

Other Conditions: Hypertension and Cardiac Disease — Couple years

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R J Young

Address 4724 C Baltimore Md Date signed 11/13/48 M D

G68531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G68531
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Spring Lake Way
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Edwin Mitchell Sturtevant (Edwin Mitchell Sturtevant)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-05-6704

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Edwin M. Sturtevant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1887

8. AGE: Years 61 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Frank Sturtevant
13. Birthplace New Jersey

MOTHER
14. Maiden Name Hattie Hart
15. Birthplace New York

16 (a) Informant Mr. C. E. Sturtevant (Son)
(b) Address 13 Ballo t.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Morgan
(b) Address 108 W North Ave.

19 (a) NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 19 48 at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 19 46 to Nov. 12 19 46 and that I last saw h im alive on Nov. 12 19 46

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. Rue Thieme M D
Address U. M. H. Date signed 4/12/48

668532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. 668532

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 333 N Charles St

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Va (b) County

(c) City or town Portsmouth

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Douglas Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3 (a) FULL NAME Mrs. George Williams

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs. George Williams

Rebecca L/ Williams 6 (c) If alive, give [redacted] years

7. Birth date of deceased (mo., day, yr) April 4, 1908

8. AGE: Years	Months	Days	If less than one day
40	7	9	..... hr. ..... min.

9. Birthplace New York (Town, County, and state)

10. Usual Occupation Auto Salesman

11. Industry or business Auto Salesman

FATHER

12. Name Mrs. Geo. Williams

13. Birthplace

MOTHER

14. Maiden Name Helen Lorkeritz

15 Birthplace

16 (a) Informant Wife

(b) Address 624 Douglas Ave - Portsmouth Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 14 1948 (month) (day) (year)

(c) Cemetery or crematory

Location Portsmouth Va.

18 (a) Funeral director William J. Tickner & Sons

(b) Address North & Pennsylvania Aves.

19 NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1948 to Nov 13 1948 and that I last saw him alive on Nov. 13 1948

Immediate cause of death Uremia

Chalasion

Due to Pneumonia + Peritonitis

abscess

Due to Duodenal ulcer (resected)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-18-48 - Abd. Exploration

Major findings of operation: 11-1-48 - Subphrenic + Pneumatic abscess

of autopsy:

Duration

PHYSICIAN Underline the cause to which it should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide 0

(b) Date of occurrence 0 at M

(c) Where did injury occur? 0 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? 0 While at work? (Specify type of place)

(e) Means of injury 0

23. Signature George O. Thomas M. D.

Address 333 N Charles St Date signed 11-13-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68533

J1 - 121681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G68533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Marzuserini or Anita Marzucchini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife late Ferruggio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Giuntoli
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 (a) NOV 15 1948 (Date rec'd by registrar) Lemington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 19 48 at 5.20 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 48 to Nov. 13 19 48. and that I last saw h er alive on Nov. 13 19 48.

Immediate cause of death Carcinoma of Cervix — Generalized metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J. Carr M.D.
Address 1910 Eastern Ave Date signed Nov. 13 1948

VS 150

G68534 B.C. 48-28620

BALTIMORE CITY HEALTH DEPARTMENT

Hospital Disposal CERTIFICATE OF DEATH 159

Registered No. G68534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mcean

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-4-48

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Mcean
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth Webster
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) Temperton Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1948 at 7 57 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948 to 11-5 1948. and that I last saw him alive on 11-5 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C Brennan M. D.
Address Johns Hopkins Date signed 11-6-48

G68535 Hospital BC-48-24366 Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G68535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1431 Bounty Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl "Dora" Shears

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-48

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Dora Shears

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-1948 to 11-10-1948, and that I last saw her alive on 11-10 1948

Immediate cause of death: Cong. atelectasis

Due to: Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature a. c. Long M. D.

Address Johns Hopkins Hosp Date signed 11-11-48

VS 150

T68536 47 BC-46-23517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 6

(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6527 Cleveland Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Baughman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-1-48

8. AGE: Years	Months	Days	If less than one day
		8 hr.	min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jessie Baughman

13. Birthplace ?

MOTHER 14. Maiden Name Gwendolyn ?

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9- 1948, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1948, to 11-9- 1948, and that I last saw him alive on 11-9- 1948.

Immediate cause of death

Conq. atelectasis

Due to

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. C. Young M D

Address Johns Hopkins Hosp. Date signed 11-11-48

VS 150

G68537 BC - 48-2260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Whitaker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-1948

8. AGE: Years | Months | Days | If less than one day: 7 hrs min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Dorothy Ball
13. Birthplace Md

MOTHER 14. Maiden Name Alfreda Whitaker
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 6:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11-6-1948 to 11-6-1948 and that I last saw him alive on 11-6-1948

Immediate cause of death: Asphyxia — Duration

Due to: Atelectasis

Due to: Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Hang M.D.
Address Johns Hopkins Hosp. Date signed 11-9-48

VS 150

G68538

JL -123842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G68538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1941 Sponson St. -30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME L. Nannie Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Joseph (D) Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	18	hr. min.

9. Birthplace Va. (Culpeper Ct.) (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Music Uniform Co.

FATHER
12. Name Joseph Stone
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Simms
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director Krauss Funeral Home
(b) Address 216 D. Charles St.

19 (Filed) NOV 15 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948 at 10.30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 18 1948 Nov. 10 1948, and that I last saw her alive on Nov. 10 1948

Immediate cause of death: Cerebrovascular accident — Duration: 2 days

Due to

Due to

Other Conditions Carcinoma of gall bladder & liver metastasis
(Include pregnancy within 3 months of death)

Date of operation 10/26/48

Major findings of operation: Carcinoma of gall bladder, extensive liver metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman E. Cole M.D.

Address 1772 Eastern Avenue Date signed 11/15/48

VS 150

82a

668539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668539 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 5-0-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME SOPHIE GOLDBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1881

8. Age: Years 67 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Mrs. Ethel Klaubert
(b) Address 2910 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or Crematory
Location New Cross, N. Y.

18 (a) Funeral director Jos. Lewis Inc.
(b) Address 2406 Eastern Ave Balto

19 (a) (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

NOV
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948 at 12 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 11-14 1948 and that I last saw her alive on 11-14 1948

Immediate cause of death Bronchopneumonia — Duration

Due to Cerebral Thrombosis

Due to

Other Conditions Old hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 11-14-48

C68540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. C68540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 W. Lombard St.
(c) Hospital or institution: 18 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 W. Lombard St. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arthur W. Smith

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-12-5372

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edith Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1887

8. AGE: Years 61 | Months 6 | Days 26 25 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business Retired

FATHER
12. Name John J. Smith
13. Birthplace Mass.

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Smith
(b) Address 1033 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) NOV 15 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 3.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 11 1948 to Nov 12 1948 and that I last saw him alive on Nov 12 1948

Immediate cause of death	Duration
Myocardial degeneration - insufficiency	Several Years.
Due to arteriosclerotic heart disease with cardiac hypertrophy & congestive failure	
Due to Generalized arteriosclerosis	
Other Conditions Gangrene of toes, left foot following infections and Suppurative paronychia. (Include pregnancy within three months of death)	3 weeks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Michel, M. D.
Address 2901 Edmondson Ave Date signed Nov 13 1948

VS 150

X

G68541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1235 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1235 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Junita C. G. Tynes

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-9624

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Marride

6 (b) Name of husband or wife Louis Tynes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 20, 1901

8. AGE: Years	Months	Days	If less than one day
47	3	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gantt
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cooper
15. Birthplace Md.

16 (a) Informant Mr. Louis Tynes
(b) Address 1235 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 12, 1948 at 12-30

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 8 1948 to Nov. 12 1948, and that I last saw h er alive on Nov. 12 1948

Immediate cause of death: Cerebral Hemorrhage, left, (Paralysis of whole right side) — Duration: 4 days

Due to Undetermined

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter M. Donald, M.D.
Address 344 N. Carey St. Date signed 11/13/48

VS 150

G68542 BC 52 4091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G68542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Ashburton St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard Stein
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosalie Stein
15. Birthplace Baltimore

16 (a) Informant Rosalie Stein
(b) Address 2217 Ashburton Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 9 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct, 28, 1948 at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Oct 25 1945, and that I last saw her alive on Oct 25 1945

Immediate cause of death Subarachnoid Hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sydney C. Warren M.D.
Address Sinai Hospital Date signed Nov 9/49

G68543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68543

BC-48-16021 1600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument ST. and Rutland Ave.

(c) Hospital or institution:

Sinai Hospital of Baltimore, Inc.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W.Va. (b) County

(c) City or town Parkersberg
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Baby Girl Cooley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1948

8. AGE: Years	Months	Days	If less than one day
		1/2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name C. D. Fore

13. Birthplace Not Known

MOTHER

14. Maiden Name Clara B. Cooley

15. Birthplace West Virginia

16 (a) Informant Clara B. Cooley

(b) Address Parkersberg, W. Virginia

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo NOV 9 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 15 1948 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death

(a) Atelectasis

Interstitial Emphysema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
-

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Melvin D. Kappelman M.D.

Address 817 St. Paul St Date signed 11/5/48

G68544 BC-41-21872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G68544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital of Baltimore INC
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5731 Edgemark Rd.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Boellner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1948

8. AGE: Years	Months	Days	If less than one day
			22 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otto Carol Boellner
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Peggy Wax
15. Birthplace Virginia, Norf

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 9 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 9 1948.
and that I last saw him alive on Oct 9 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hosp. Date signed 11-9-48

VS 150

668545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. 668545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Second Ave. S.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry G. Lee Sr.
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) March 25, 1889

8. AGE: Years	Months	Days	If less than one day
59	7	18	hr. min.

9. Birthplace Snow Hill, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own Home

FATHER
12. Name Edward T. Maddox
13. Birthplace Near Princess Ann, Md.

MOTHER
14. Maiden Name Mary A. Miller
15. Birthplace Near Salisbury, Md.

16 (a) Informant Harry G. Lee Sr.
(b) Address 209-2ND. Ave. S.W. Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Nov 15 1948 (Date received by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1948, at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-48 1948, to 11-13 1948, and that I last saw h-m alive on 11-13 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Pneumonia

Due to

Other Conditions Appendicitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address University Hospital Date signed 11-13-48

G68546 B.C. 48-24698

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G68546
Registered No.

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hrs days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 16 · Box 213A Zone 21
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Beal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	infant

6 (b) Name of husband or wife O

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1948

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Clyde Beal
13. Birthplace Warren, Ohio

MOTHER
14. Maiden Name Clara May Morrow
15. Birthplace Ambridge, Pa.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 11 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948 to 11-7 1948, and that I last saw her alive on 11-7-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease - deformity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Bold M. D.
Address University Hosp Date signed 11-7-48

VS 150

X

G68547 3C - 48-2372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G68547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave & Madison St

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5635 Loftician Rd #12
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Burbage

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Wht. | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1948

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 2 hr. 16 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Hugh Lynn Burbage

FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Ogle Burch

MOTHER 15. Birthplace Oakley, Md.

16 (a) Informant Hugh Lynn Burbage

(b) Address 5635 Loftician Rd #12

17 (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory _____

Location University Medical School NOV 8 1948

18 (a) Funeral director _____

(b) Address _____

19 (a) NOV 15 1948 (b) _____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948. 6:49 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948. to 11-2 1948., and that I last saw him alive on 11-2 1948.

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Md. Gen. Hosp. Date signed 11-8-48

VS 180

G68548

BC-48-24462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G68548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts.

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 508 Green St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Sam Bradley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/27/48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER

12. Name Sam Bradley

13. Birthplace

MOTHER

14. Maiden Name Rosalie

15. Birthplace

16 (a) Informant Rosalie Bradley-mother

(b) Address 508 E. Green St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 11 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1948, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1948, to 11/3 1948 and that I last saw her alive on 11/3 1948

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions Asphyxia Diarrhea

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work)

(Specify type of place)

(e) Means of injury

23. Signature Nicholas Mallis M.D.

Address Univ. Hosp. Date signed 11/10

VS 150

G68549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State W. Va. (b) County
(c) City or town Bluefield (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Bluefield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME N. Walter Snipe

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Unknown

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 8 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1948, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil L. Ryan M.D. Medical Examiner.

Date signed 11/14/48

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68550
Registered No.

IS-122486

10

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS 4-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Metcalf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 8, 1908

8. AGE: Years	Months	Days	If less than one day
40	6	24	hr. min

9. Birthplace Maine
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER
12. Name Lee Metcalf
13. Birthplace Maine
14. Maiden Name Gertrude Watt
15. Birthplace Maine

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1948 for Hunter Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948 to 11-2 1948 and that I last saw h[im] alive on 11-2 1948

Immediate cause of death - PROBABLE
(1) PULMONARY EMBOLISM
Due to
(2) DIPHTHERITIC POLYNEURITIS
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NO

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Warren E. Cotta M. D.
Address Balto City Hospital Date signed 11/10/48

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68551 Medical Examiner's Case G68551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] & Charles St
(c) Hospital or institution: Union Memorial Hosp 9 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Old York Rd (If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Herbert Harrington

3 (b) If veteran, name war	3 (c) Social Security Account No.
? W	? NW

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs Edith Harrington
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Feb. 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	9	12	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation - Painter
11. Industry or business - none

FATHER 12. Name James Harrington (deceased)
13. Birthplace England

MOTHER 14. Maiden Name Harriet Bailey (deceased)
15. Birthplace England

16 (a) Informant Mrs Edith Harrington
(b) Address 3804 Old York Rd - Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Co, Md

18 (a) Funeral director Wilhoyte & Lee
(b) Address 1217 N Eutaw St

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1948 at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948, to 11-14 1948.
and that I last saw him alive on 11-14 1948

Immediate cause of death (Enter only one cause per line for a, b, and c.)
(a) Cerebro - Vascular Accident — Duration

Due to
(b)

Due to
(c)

Other Conditions Fractured Rt Femur.
(Include pregnancy within 3 months of death)

Date of operation 11-12-48
Major findings of operation: Wm. H. Hammer, M.D.
of autopsy: Per [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11-2-48 at 10. A M
(c) Where did injury occur? Balt, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify) While at work? no
(e) Means of injury fell from window

23. Signature [illegible] M. D.
Address Union Memorial Hosp Date signed 11-14-48

VS 15

X

To be filled in by chief medical examiner

G68552

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68552 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hosp. Ward 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Alverda Grasty

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Nathaniel G

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr): Oct 26 1870

8. AGE: Years 78 | Months 0 | Days 18 | If less than one day: 19 hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Smith
13. Birthplace: Md.

MOTHER
14. Maiden Name: Laura Gilbert
15. Birthplace: Md.

16 (a) Informant: Nathaniel Grasty
(b) Address: 2217 Maryland Ave

17 (a) Burial: (b) Date thereof: 11/16/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18 (a) Funeral director: Wilson & Co.
(b) Address: 1217 E. Fort Ave

19 (a) Nov 15 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-1948, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-1948 to 11-14-1948 and that I last saw her alive on 11-14-1948.

Immediate cause of death	Duration
Acute cardio respiratory failure	
Due to Chronic Heart failure	
Due to Hypertension, arteriosclerosis, senile changes	
Other Conditions Pathological findings, not known.	

(Include pregnancy within 3 months of death)

Date of operation: CERTIFICATION APPROVED BY Wm. H. Hammer, M.D. Per

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: ?
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 11-10-48 at — A.M. P.M.?
(c) Where did injury occur? Balto., Balto., Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify) (Place) While at work?
(e) Means of injury Slipped and fell to floor Fracture of R. femur

23. Signature C. D. Thomas, M.D.
Address Mercy Hosp. Date signed 11-14-48

VS 100

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G68553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HIPPLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1895

8. AGE: Years	Months	Days	If less than one day
53 yrs.		14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Andrew Hippler
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Market
15. Birthplace Germany

16 (a) Informant Mrs. Lilly E. Martin
(b) Address 310 Germania Ave., Schenectady 7, New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Avenue

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 6009 Harford Road

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948, at 7:25PM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy / Inspection / Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Ryan M.D.
Medical Examiner
Date signed November 11, 1948

VS 151

G68554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hos ital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-01
(e) Length of stay in Baltimore (yrs., mos., or days) 19-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ALBERT ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Middlesex County, Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Peachie Winkfield
15. Birthplace Virginia

16 (a) Informant Richard Toliver
(b) Address Fairfield, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof nov 19/1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Signature for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 11:45 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive arteriosclerotic cardio-vascular disease
Acute c ngestive heart failure
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Roy M.D. Medical Examiner.
Date signed 11-11-48

VS 151

X

G68556 2 copy of duct

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G68555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution:
S.B.G.H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 169-09-8487

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 20 1886

8. AGE: Years 62 | Months 8 | Days 9 | If less than one day 21 hr. min.

9. Birthplace [redacted]
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business —

FATHER 12. Name Nathaniel Walton

13. Birthplace Alabama

MOTHER 14. Maiden Name Lucy Hunley

15. Birthplace N. C.

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof Nov 15-1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams

(b) Address 1515 McElderry St

19 NOV 15 1948 (b) Huntington W. Va. Registrar
(Date rec'd by Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/48 1948 at 1134 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1948 to 11/12 1948, and that I last saw him alive on 11/12 1948.

Immediate cause of death Shock

Due to Hemorrhage

Due to Evisceration

Other Conditions Ca. of head of pancreas + metastases
(Include pregnancy within 3 months of death)

Date of operation 11/3/48

Major findings of operation: Ca. of head of pancreas + metastases

of autopsy: [illegible]

Duration: 1 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan E. Trevaskis M. D.

Address 1213 Light St Date signed 11-13-48

Allan E. Trevaskis 128

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G68556

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Huggins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-30-75

8. AGE: Years 73 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace NC (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Alexander Huggins
13. Birthplace NC

MOTHER 14. Maiden Name Mary Seldon
15. Birthplace NC.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 16 48 (Month) (Day) (Year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location

18 (a) Funeral director Mrs. Elliott Daugherty
(b) Address 1129 N. Carlton St.

19 Nov 15 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 9 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10-1948 to 11-12-1948 and that I last saw him alive on 11-12-1948.

Immediate cause of death	Duration
Unknown.	
Due to Pneumonia RUL.	3 days
Due to ? Cerebrovascular accident.	
Other conditions Parkinsons disease (Include pregnancy within 3 months of death)	5 yrs. Estim.

Date of operation
Major findings of operation:
of autopsy Lobar Pneumonia

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Calkins
Address Johns Hopkins Hosp. Date signed 11/12/48
E. Calkins

VS 150

Medical Examiner Case 668557 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G68557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount Ave.
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 S. Decker St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances Rusin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife George H. Rusin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	10	20		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation House-Keeper
11. Industry or business

FATHER
12. Name Frank Bayner
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine —
15. Birthplace Poland

16 (a) Informant Record
(b) Address Church Home and Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenmar Hill Rd

18 (a) Funeral director Selby Zeh-da
(b) Address 463 S. Wolfe St

19 (a) Nov 15 1948 (Date received by Registrar) (b) Huntington Phillips, M.D. (Signature of Registrar)

CERTIFICATION APPROVED BY Henry J. Mahoney, M.D. for JOHN R. DAVIS, M.D. CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1948, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1948, to 11-13 1948, and that I last saw her alive on 11-13 1948

Immediate cause of death	Duration
Respiratory arrest	30 min.
Due to ~~Cerebro vascular Accident~~ Acute Subdural hematoma	4½ hrs.
Due to fall in home	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy Acute Subdural hematoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 13 Nov 48 at 1:15 P M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall on stairs

23. Signature Richard M. Garrett M.D.
Address Church Home & Hospital Date signed 11-13-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G68558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST MERSON

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Molly Merson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1905

8. AGE: Years 43 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Plaster

11. Industry or business

FATHER
12. Name Frank Merson
13. Birthplace Howard Co.

MOTHER
14. Maiden Name Agnes Smith
15. Birthplace Howard Co.

16 (a) Informant Molly Merson
(b) Address 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Savage Cemetary
Location Howard Co., Md.

18 (a) Funeral director Ridgely Selby
(b) Address Laurel, Maryland

19 (a) NOV 15 1948 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948 19 . at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound, Right Temple

Due to

Other Conditions Marked Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 14, 1948 approx. 1:30 A.M.
(b) Where did injury occur? 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature John R Dawn, M.D. Medical Examiner
Date signed 11, 15, 48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G68559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G68559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WEST BALTIMORE GEN. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 PUPLAND ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. HAEGERICH

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-8555

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife IDA (ROLLMAN)
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) MAY 30, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	14	hr. — min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation MECHANIC
11. Industry or business

FATHER
12. Name ALBERT HAEGERICH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ELIZABETH WALTERS
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS CHARLES W. HAEGERICH
(b) Address 1502 PUPLAND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 / 13 / 48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) NOV 15 1948 (Rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov 1948, at 1:44 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Nov 1948, to 13 Nov 1948, and that I last saw h[illegible] alive on 13 Nov 1948.

Immediate cause of death Carcinoma of the body of the pancreas — Duration 1 wk
Due to Hepatic insufficiency — Duration ?
Due to metastatic carcinoma due to carcinoma of the body of the pancreas
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Young, M.D.
Address W. B. & H. Hospital Date signed 13 Nov 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 668560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital 18 2W
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1055 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA GRANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	-	hr. min.

9. Birthplace Cristfield, Maryland
(Town, county, and state)

10. Usual Occupation Housefife

11. Industry or business

FATHER
12. Name Charles Weeks
13. Birthplace Cristfield, Maryland

MOTHER
14. Maiden Name Maggie Weeks
15. Birthplace Cristfield, Maryland

16 (a) Informant Alfonzo Weeks
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16-48 (month) (day) (year)

(c) Cemetery or crematory
Location Cristfield Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Edmondson ave

19 (a) NOV 15 1948 (b) Lexington Funeral Home
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 1:39 P M

21. I certify that I took charge of the remains described above, held an Insp. & inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Hypertensive C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sobrado M.D.
Medical Examiner.
Date signed 11/11/48

X

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68561

BC- 48-27673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

Registered No. G68561

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement or omission should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins ave

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d

(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2614 W. Franklin St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby girl Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 11, 1948

8. **AGE:** Years | Months | Days | If less than one day: 14 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation New born

11. Industry or business

FATHER

12. Name John W. Walker

13. Birthplace

MOTHER

14. Maiden Name Rita Lloyd

15. Birthplace Md

16 (a) Informant John Walker

(b) Address 2614 W. Franklin St

17 (a) Buried (b) Date thereof 11/15/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Saffron Sons

(b) Address 1827 W. North Ave

NOV 15 1948 (b) Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** November 13, 1948, at 9:25 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Respiratory failure

Due to: a Cardiac failure.

Due to: Extrema hydrocephalus

Other Conditions: large Spina bifida
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. **Signature** Jos. A. Magruder

Address 2 Agnes Hosp. Date signed 11/13/48

Jos. A. Magruder M.D.

VS 150

668562 BC-48-19683 X ✓ 668562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 7309 Hughes Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. HANEY, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1948

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John J. Haney, Sr.

13. Birthplace Drake, S. C.

MOTHER 14. Maiden Name Margaret Bittorf

15. Birthplace Baltimore, Md.

16 (a) Informant John J. Haney, Sr.

(b) Address 7309 Hughes Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11- -48 (month) (day) (year)

(c) Cemetery or crematory Western

Location Edgn Ave

18 (a) Funeral director Geo H. Leimbach

(b) Address 1 W Lexington St

19 (a) Date received by registrar Nov 15 1948 (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 2.50a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-14-48 at approx. 2.00 p. M.

(b) Where did injury occur? 7309 Hughes Ave. Sparrows Point

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Mechanical suffocation due to bedclothes

23. Signature Earl K. Rose M.D. Medical Examiner.

Date signed November 15, 1948

G68563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68563

1226

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 59yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Streeper Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Emil Morawski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Morawski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	10			

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Marion Morawski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Smuzinska
15. Birthplace Poland

16 (a) Informant Helen Morawski
(b) Address 701 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory. Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 NOV 15 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 9:10 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/8/ 1948 to 11/13/ 1948, and that I last saw him alive on 11/13/ 1948.

	Duration
Immediate cause of death: Cardio-respiratory failure	
Due to: Generalized peritonitis	7 days
Due to: Gangrene of bowel from volvulus and mesentaric	1 wk.
Other Conditions: Coronary occlusion	

(Include pregnancy within 3 months of death)

Date of operation 11-8-48
Major findings of operation: Volvulus c. gangrene of bowel
of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify which)
(e) Means of injury

23. Signature J. Joseph Kruger
Address 1400 N. Caroline St. Date signed 11-13-48 M.D.

668564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. 668564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorsey Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-10-92

8. AGE: Years	Months	Days	If less than one day
56	2	-	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Fisher
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15-1948 (month) (day) (year)
(c) Cemetery or crematory National Location Frederick Ave. Balto. Md.

18 (a) Funeral director Bryon Eugene Knight
(b) Address 725 Edgewood Street

NOV 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 10 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948, to 11-10 1948, and that I last saw her alive on 11-10 1948

Immediate cause of death: Tuberculous pneumonia — Duration

Due to Ruptures bronchial lymph node

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: TB pneumonia, R lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature John Calvin Harvey M. D.
Address Johns Hopkins Hospital Date signed 11-11-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

931

Registered No. G68565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Z. Roland (George Zebulon Roland)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie M. Roland

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1875

8. AGE: Years 73 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Kent Co., Md. (Town, county, and state)

10. Usual Occupation Butcher - retired

11. Industry or business

FATHER
12. Name Enoch Allen Roland
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Mrs. Sydney H. Raab
(b) Address 3006 Du Boise Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month, day, year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Nov. 1948, at 10:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Pernicious Anemia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner
Date signed 14 Nov. 48

Form VS 151

Please read carefully. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G68566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G68566 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 07

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 N. Hilton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH Jennings TROTT

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 214-26-9323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Doris K. Trott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1896

8. AGE: Years	Months	Days	If less than one day
51	11	5	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired Police Officer

11. Industry or business

FATHER
12. Name: Thomas Trott
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Sarah McDevitt
15. Birthplace: Ireland

16 (a) Informant: Mrs. Doris K. Trott
(b) Address: 2609 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: North & Pennsylvania Avenues

19 (a) (Date rec'd by registrar) (b) Tentington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948 at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1517
(a) Date of injury 11-13-48 at 8:19 A. M.
(b) Where did injury occur? Hilton St. & Piedmont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature C.C.Merrill, M.D. Medical Examiner M.D.
Date signed 11-13-48

G68567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G68567 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MICHAEL STREB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	~~Married~~

6 (b) Name of husband or wife Mary A. (nee McDonald)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 4, 1913

8. AGE: Years	Months	Days	If less than one day
35	1	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business U. S. Industrial Chemical

FATHER
12. Name John A. Streb
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth C Hennessie
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Mary A. Streb
(b) Address 3139 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (c) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 NOV 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. at ? M.
(b) Where did injury occur? Gwynn Falls Stream
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Medical Examiner. M.D.
Date signed 11/15/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

668568
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luvenia Bertha Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Charles R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 12, 1875

8. AGE: Years	Months	Days	If less than one day
73	1	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Bell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary L. Patterson
15. Birthplace Baltimore

16 (a) Informant Mrs. Ida May Myers
(b) Address 1712 Broadway.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) NOV 16 1948 Registered by (Signature of Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 19 48, at 1 30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 19 48 to Nov 13 19 48, and that I last saw h alive on Nov 13 19 48

Immediate cause of death: Lobular Pneumonia — Duration 2 days
Due to: Ch. Bronchitis
Due to: Ch. Gastritis
Due to: Ch. Valvular Heart Disease — 4 yrs
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1580 E. 33rd Date signed 11/15/48.
M D

G68569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

X 18 G68569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Woodson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Carrie Anthony
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Nov 11 1875

8. AGE: Years 73 | Months — | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Dairy Business

FATHER 12. Name Calvin E Woodson
13. Birthplace Md

MOTHER 14. Maiden Name Samantha Marker
15. Birthplace Md

16 (a) Informant Mrs Lawrence Woodson
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/48 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Upton
(b) Address Hampstead Md

19 (a) (Date received by Registrar) Washington Williams, M.D. Registrar
NOV 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 13 1948, and that I last saw h[illegible] alive on Nov 13 1948.

Immediate cause of death Hemorrhage & Circulatory Shock — Duration

Due to Gastric Bleeding

Due to Duodenal Ulcer

Other Conditions Pneumonitis Left Base

(Include pregnancy within 3 months of death)

Date of operation Nov 3 1948

Major findings of operation: marginal enterostomy ulcer + Multiple Adhesions

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address University Hospital Date signed 4/13/49

X

Please write in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 112

G68570
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7 days
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2005 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Dennish Shugars

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 215-03-2254

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	17	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Salesman.
11. Industry or business: Dents furnishings

FATHER
12. Name: James Shugars.
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Alice McClellan
15. Birthplace: Maryland.

16 (a) Informant: Robert Shugars.
(b) Address: 2005 Homewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Hampstead
Location: Carroll Co. Md.

18 (a) Funeral director: Edward C. Tipton
(b) Address: Hampstead Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 1948

VS 192

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 1948, at 8:5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948, to Nov. 14 1948, and that I last saw him alive on Nov. 14 1948.

Immediate cause of death	Duration
Cardiac failure	2 hrs.
Due to: Chronic bronchial asthma	20 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: John Robert Shell, M.D.
Address: Mercy Hospital Date signed: Nov 14, 1948

G68571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G68571 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: RICHARD ILES

3 (b) If veteran, name war

3 (c) Social Security Account No. 165-01-4197

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ida Iles Cornish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1889

8. AGE: Years	Months	Days	If less than one day
59	5	11	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Watchaman

11. Industry or business Transfer Company

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ida Iles Cornish
(b) Address 921 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director ELROY O. WILSON
(b) Address 1007 Brantly ave

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 7 A.M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-15-48

151

X

668572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

668572 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Ashland Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Ashland Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman F. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 22, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	20	hr. min.

9. Birthplace Washington Co., Md.
(Town, county, and state)
10. Usual Occupation Die grinder,
11. Industry or business

FATHER
12. Name John Snyder
13. Birthplace Maryland

MOTHER
14. Maiden Name Emman Connor
15. Birthplace Maryland

16 (a) Informant Mrs. Bertha Snyder
(b) Address 4508 Ashland Ave.

17 (a) Burial (b) Date thereof 11/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) 5 1948 (b) Washington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-2 1948 to Nov 12-1948.
and that I last saw him alive on Nov 12 — 1948.

Immediate cause of death Myocardial insufficiency
Pulmonary Edema

Due to Chronic Nephritis.

Due to Chronic Arteriosclerosis

Other Conditions Acute Cystitis,
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 5yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm F Reese M.D.
M. D.
Address 1564 Mellon Ave Date signed 11/23/48

G68573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G68573 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Siani Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Smith,

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Gladys Smith (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 15 1905

8. AGE: Years 41 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Asst Foreman

11. Industry or business Balto Paint & Color Co

FATHER
12. Name Rosa Rinks
13. Birthplace Ga

MOTHER
14. Maiden Name Geo O Smith
15. Birthplace Ga

16 (a) Informant Mrs Gladys Smith
(b) Address 1316 N Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948, at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 (1948 1948, to 11/13 1948, and that I last saw him alive on 11/13 1948.

Immediate cause of death Hypertensive Ht. Dis
Arteriosclerotic Ht. Dis
Cerebral Embolus, Bronchopneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie Oxman M D
Address Sinai Hosp Baltimore Date signed 11/13/48

Washington Williams, M.E.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

✓

G68574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto Hospital
(c) Hospital or institution: 25 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Cadley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Gertrude Workenfuss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Edward J Workenfuss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1895

8. AGE: Years 53 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Montgomery Ryan

13. Birthplace Md

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Wm Weidner

(b) Address 1618 Pentwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/48 (month) (day) (year)

(c) Cemetery or crematory St Pauls Cem

Location Violetsville Balto

18 (a) Funeral director Uhlemeyer Funeral Homes

(b) Address 2008 Orleans St

19 (a) 5 1949 (Date rec'd by registrar) (b) Huntington Hillsville, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov 1948 at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema with Anasarca

Due to Myocardial Degeneration

Other Conditions Hepatic Cirrhosis due cardiac failure, chronic
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm F. Kammer M.D.
Medical Examiner.

Date signed 13 Nov. 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use additional sheet of this form if more space is required. Fill in all information called for carefully supplied. Use

VS 151

93 D

68575 Welkner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Women's & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Roth Welkner

3 (b) If veteran, name war

3 (c) Social Security Account No. [illegible]

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Gustav M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1863

8. AGE: Years 85 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Roth
13. Birthplace

MOTHER
14. Maiden Name Margaret Hunderfer
15. Birthplace

16 (a) Informant L. H. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director William Cox Esq
(b) Address 1217 E. Fort Ave

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Lexington Millinery, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948, at 2:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 12 1948, and that I last saw h[illegible] alive on Nov. 12 1948.

Immediate cause of death Cardiac Failure with Pneumonia edema — Duration

Due to Myocarditis, Chronic

Due to arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address 4-E-33rd St - 18 Date signed Nov. 19, 1948

V S 150

X

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

668576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13a

Registered No. 668576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Canvas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Canvas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE I. COOPER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Arthur [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 14, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	28	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Lease
13. Birthplace Va.

MOTHER
14. Maiden Name Martha MacDonald
15. Birthplace Va

16 (a) Informant Beatrice Cooper
(b) Address 911 Canvas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month, day) (year)
(c) Cemetery or crematory Forest Lawn
Location West Virginia

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 . at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 12 1948, and that I last saw h[illegible] alive on Nov 11 1948.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Arterio-Sclerotic Cardio Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Paul Lutin
Address 320 Independence Date signed 11/13/48 M/D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G68577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Longwood St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Gregory (Katherine Gregory)

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1869

8. AGE: Years 78 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace Eatons, W. Va. (Town, county, and state)

10. Usual Occupation Nurse.

11. Industry or business

FATHER 12. Name Thomas Gregory,
13. Birthplace Ireland.

MOTHER 14. Maiden Name Ann Campbell,
15. Birthplace Ireland.

16 (a) Informant Mrs. B. C. Ryan,
(b) Address 1407 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Co-Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948 at 8 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1948 to 11-14 1948 and that I last saw her alive on 11-14 1948

Immediate cause of death: Coag. W. Failure — Duration

Due to Degeneration of Brain

Due to

Other Conditions Senile Debility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute pancreatitis

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? (Specify type) While at work?
(e) Means of injury

23. Signature Geo. Richmond
Address Bon Secours Date signed 11-14-48 M.D.

V8 153

G68578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68578

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton & Baltimore Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)

(d) Street No. Garrison Field Rd
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME H. Edward Walter

3 (b) If veteran, name war World War # 1

3 (c) Social Security Account No. 216-01-6657

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Grace Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/1894

8. AGE: Years	Months	Days	If less than one day
54	9	13	hr min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Stock clerk

11. Industry or business U. S. Rubber Co.

FATHER

12. Name Harry J. Walter

13. Birthplace Md

MOTHER

14. Maiden Name Emma C. Price

15. Birthplace Md

16 (a) Informant Mrs. Grace Walters,

(b) Address Garrison Road-Owings Mills Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Baltimore, Md.

18 (a) Funeral director L. Vernon Lemmon.

(b) Address 4611 Park Heights Ave.,

19 (a) NOV 15 1948 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1948 at 10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/9 1948 to 11/13 1948 and that I last saw h living on 11/13 1948

Immediate cause of death Cardio vascular collapse

Due to Coronary Occlusion

Due to

Other Conditions Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 11/12/48

Major findings of operation: Hypertrophied prostate

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Walter J. Bernard M.D.

Address St. Agnes' Hosp. Date signed 11/13/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182B

Registered No. 668579

668579 B.C. 46-21707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH M. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1948

8. AGE: Years | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Charles Wilson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Doris Furguson
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Doris Wilson
(b) Address: 209 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral Director: Joseph A. Lively
(b) Address: 646 W Baltimore St.

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948 at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-48 at ? A. M.
(b) Where did injury occur? 209 N. Mount St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) no
(d) Means of injury Overlay of parents (bed)

23. Signature Earl L. Kruger M.D. Medical Examiner.
Date signed 11-15-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 668580

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1091 N. Gilmor St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1091 N. Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Melvin McMillian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary McMillian

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr April 1898

8. AGE: Years 50 | Months 7 | Days | If less than one day hr. min

9. Birthplace Gilson N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Melvin McMillian

13. Birthplace Gilson N.C.

MOTHER 14. Maiden Name Mary ?

15. Birthplace Gilson N.C.

16 (a) Informant Mary McMillian.

(b) Address 1091 Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 6 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N. Edgewood St

19 (a) NOV 5 1948 (Date received by Registrar) Kathryn Williams, Mrs Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/ 48 to 11/11/48 and that I last saw him alive on 11/11/48

Immediate cause of death	Duration
(a) Acute Impaction	1 days
Due to (b) Cerebral Hemorrhage	4 days
Due to (c) Hypertension	3 days
Other Conditions Cancer	2 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. T. [illegible] M.D.

Address 322 N. Edgewood St Date signed 11/8/48

668581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 668581

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 S. Collins Ave -
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Florence Dutrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband late DAVID N DUTROW

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) MAY 11, 1874

8. AGE: Years 74 | Months 6 | Days 3 | If less than one day hr min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business —

FATHER 12. Name Hm. Haney - decd

13. Birthplace Va!

MOTHER 14. Maiden Name Anna Sullivan decd

15. Birthplace Tenn.

16 (a) Informant MR. CLARENCE DUTROW

(b) Address 105 S. MORLEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 17 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3800 FREDERICK AVE

18 (a) Funeral director Hans H Wyse

(b) Address 4100 Edmondson Ave

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 14 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948 to 11/14 1948 and that I last saw her alive on 11/14 1948

Immediate cause of death
Ca head of Pancreas
& metastasis —
Duration

Due to Biliary obst. —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 51, Agnes Way Date signed 11-19-48

VS 153

G68582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G68582
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. OHM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	1 19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Carr
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ---
15. Birthplace Md.

16 (a) Informant Mr. Henry W. Ohm
(b) Address 3400 Edmondson Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 17 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Harry A. Wilson
(b) Address 4106 Edmondson Ave.

19 NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 at 1:50PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to Incised wound of neck

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 13'48 at Approx. 8 A.M.
(b) Where did injury occur? 3400 Edmondson Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slashed throat with paring knife

23. Signature Emil Ruzga M.D.
Medical Examiner.
Date signed 11/15/48

VS 151

G68583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles A. Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh. Tb	Married

6 (b) Name of husband or wife Mrs. Regina Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 22 (~~1899~~) 1899

8. AGE: Years	Months	Days	If less than one day
49	0	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Frentz Pharmacy

FATHER
12. Name Anthony Hartman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Josephine Barber
15. Birthplace Md

16 (a) Informant Mrs. Charles Hartman
(b) Address 1804 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 '48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director Harry A. Wilhelm
(b) Address 5400 Belair Rd

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1948, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948 to 11/12 1948, and that I last saw h[illegible] alive on 11/12 1948.

Immediate cause of death	Heart Failure	Duration
Due to	Coronary Thrombosis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature William J. Womack M. D.
Address Bon Secours Hosp. Date signed 11/12/48

VS 199

Do not fold; especially important. Physician: please write the causes of death clearly and legibly.

G68584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G68584

G68584

Type or print with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 Homestead St.
(c) Hospital or institution: 4-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Walsh

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17th 1886

8. AGE: Years	Months	Days	If less than one day
62	8	28 27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Confectionary Keeper
11. Industry or business For Self

MOTHER / FATHER
12. Name Timothy Walsh
13. Birthplace Ireland
14. Maiden Name Annie O'Reilly
15. Birthplace Ireland

16 (a) Informant Mrs. Mollie V. Walsh
(b) Address 935 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4340 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) NOV 15 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Nov 14th 1948, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1948, to 11/14 1948, and that I last saw h alive on 11/13 1948.

Immediate cause of death Cerebral Hemmorhage — Duration 1 mo.
Due to Hypertension
Due to Nephritis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J. Brawley
Address 1vv ✓ See Date signed 11/15/48

68585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

Registered No. 68585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 4-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 North Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND STIVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1882

8. AGE: Years 66 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Attendent at race track

11. Industry or business

FATHER
12. Name Joseph Stiver
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Campbell
15. Birthplace Maryland

16 (a) Informant Mrs. H. Stiver
(b) Address 102 N. Monroe St.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Ladon Park
Location Frederick Rd.

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park

19 (a) NOV 15 1948 (Registered by registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 6.00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at approx. 2.30 P. M.
(b) Where did injury occur? Park Hts. & Paton Aves.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury knocked to ground during altercation

23. Signature [illegible] M.D.
Medical Examiner.
Date signed November 15, 1948

VS 131

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S. Potomac St.
(c) Hospital or institution: 1-0 r
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Potomac St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie S. Dingle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. B. Dingle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febr 24-1883

8. AGE: Years	Months	Days	If less than one day
65	8	21 20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name George Lamm
13. Birthplace Baltimore

MOTHER
14. Maiden Name Christine Effling
15. Birthplace Baltimore Md.

16 (a) Informant Francis Dingle
(b) Address Bengier 20 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elizabeth Hartz Funeral
(b) Address 115 E. West St.

19 (a) NOV 15 1948 (Date rec'd by registrar) Lemuel Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1948 at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1948 to Nov 24 1948. and that I last saw her alive on Nov 13 1948.

Immediate cause of death Coronary Occlusion — Duration 2 days
Due to Hypertensive Card-vasc dis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M. D.
Address 2843 St Paul St Date signed Nov 15, 1948

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Typewriter, with ribbon ONE ALONG INK.

G68587

HEALTH DEPARTMENT—CITY OF BALTIMORE

G68587

SOCIAL SECURITY 219-10-1478 CERTIFICATE OF DEATH 13 1a

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Sulgrave Ave St., 27 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

If U. S. Veteran specify WAR .....

2. FULL NAME CHARLES LEWIS IMHOFF 27-15

(a) Residence: No. 1621 Sulgrave Ave St., ... Ward 27

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Thompson Imhoff

6. DATE OF BIRTH (month, day, year) Feb. 4-1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Caretaker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME George Imhoff

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Matilda

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mrs. Emma Imhoff

(Address) 1621 Sulgrave Ave.

18. BURIAL, [illegible]

Place Woodlawn Cemetery Date Nov. 16-1948

19. UNDERTAKER Burgee Funeral Home

(Address) 3631 Falls Road Balto. Md.

20. FILED NOV 15 1948 Registrar. Courtesy for Williams M.D.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 13-1948. 19

22. I HEREBY CERTIFY, That I attended deceased from November 11 1948 to Nov 13 1948

I last saw him alive on Nov. 13 1948 Death is said to have occurred on the date stated above, at 6.25 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis Chronic	
Nephritis Chronic	
Other contributory causes of importance: Uremic Coma — due to Nephritis Chronic	2da

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? Usual Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) Sherman E. Mantz M. D.

(Address) 260 Manhattan Ave

Nov. 13/48

V8 a

G68588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G68588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 09

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 HOLBROOK ST. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JOSEPH SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	MARRIED.

6 (b) Name of ~~husband~~ or wife ANNE Theresa Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 23, 1898

8. AGE: Years	Months	Days	If less than one day
50	0	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county and state)
10. Usual Occupation CLERK
11. Industry or business G+E Co.

FATHER
12. Name August Schmidt
13. Birthplace Md

MOTHER
14. Maiden Name Hilda
15. Birthplace

16 (a) Informant Mrs. A.T. Schmidt
(b) Address 1503 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt

18 (a) Funeral director L.J. Puck
(b) Address 5305 Harford Rd.

19 NOV 15 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948, at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1948 to Nov. 14 1948, and that I last saw him alive on Nov. 14, 1948.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CORONARY THROMBOSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Bahen, Jr. M.D.
Address St. Joseph's Hospital Date signed 11-14-48

X

668589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 668589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Aldershot Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LAUTENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1882

8. AGE: Years	Months	Days	If less than one day
66	9	11 10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name George Lautenberger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Ruhland
15. Birthplace Germany

16 (a) Informant G. Frederick Lautenberger
(b) Address 808 Cathedral Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Maryland

18 (a) Funeral director HARRY N. ARMACOST
(b) Address 4204 Ridgewood Avenue

19 (a) NOV 15 1948 Date rec'd by registrar (b) Huntington-Mitchell, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage
Left Frontal Lobe

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at 8:19 P.M.
(b) Where did injury occur Overbrook Rd. & York Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Earl Rose M.D.
Medical Examiner.
Date signed 11-13-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

668590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 E. Fort Ave.
(c) Hospital or institution. —— (If not in hospital or institution, give name of street and number)
(d) Length of stay in hospital or inst. (yrs., mos., or days) ——
(e) Length of stay in Baltimore (yrs., mos., or days) about 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 E. Fort ave. (If rural give location)
(e) Citizen of foreign country? —— (Yes or No)
If yes, name country ——

3 (a) FULL NAME Susie A. Gardner

3 (b) If veteran, name war —— 3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles W. Gardner 6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) June 12 1879

8. AGE: Years 69 | Months 5 | Days 2 | If less than one day: hr. ____ min. ____

9. Birthplace Queen Anne's Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business ——

FATHER — 12. Name Walter Poe — 13. Birthplace Md.

MOTHER — 14. Maiden Name Mathilda Hancock — 15. Birthplace Md. (Dorset)

16 (a) Informant Mrs. Dorothy E. Zakrzewski
(b) Address 1238 E. Fort Ave., Balto 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co., Md.

18 (a) Funeral director A. Raymond Evans
(b) Address 1400 E. Eutaw St., Balto 30, Md.

19 (a) —— (b) Date received NOV 15 1948 Registrar Millicent Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sunday, Nov 14, 1948, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948 to 11/14 1948 and that I last saw her alive on 11/13 1948.

	Duration
Immediate cause of death: Arteriosclerotic heart dis.	2 y
Due to: Generalized arteriosclerosis.	?
Due to:	
Other Conditions: Cerebral arterio sclerosis.	

(Include pregnancy within 3 months of death)

Date of operation ——
Major findings of operation: ——
of autopsy: ——

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ——
(b) Date of occurrence —— at —— M
(c) Where did injury occur? —— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? —— While at work? —— (Specify type of place)
(e) Means of injury ——

Signature Julius Loebl M. D.
Address 1800 N. Howard Date signed 11/15/48

Julius Loebl X

G-68591

G68591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME LEONARD HEINEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Heineman

6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1885

8. AGE: Years: 63 | Months: 2 | Days: 11 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Laborer.

11. Industry or business: Baltimore City.

FATHER
12. Name: Rhinehardt Heineman
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Kuniguncka Maule
15. Birthplace: Germany.

16 (a) Informant: Catherine Heineman
(b) Address: 928 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: 7225 Eastern Ave.

18 (a) Funeral director: Leopold L. Zeiler
(b) Address: 901 S. Conkling St.

19 (a) (Date rec'd by registrar) NOV 15 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 12 1948 and that I last saw him alive on Nov. 12 1948

Immediate cause of death: Pulmonary tuberculosis — Acute tuberculous meningitis — Duration: 1 mo. — Nov. 48

Due to:

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: Edith Heineman

Address 872 Eastland Date signed 11 15 48 M D

X

NOV 15 1948

68592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 68592

Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2912 Stanleham Circle

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto 25

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2912 Stanleham Circle

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Married

6 (b) Name of husband or wife William A. Hall

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) March 5th 1911

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37	8	7		

9. Birthplace Balto, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Manager Hostess

13. Birthplace Va.

MOTHER

14. Maiden Name Elizabeth H. Wesley

15. Birthplace Md.

16 (a) Informant William A. Hall

(b) Address 2912 Stanleham Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17th 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location D. a. Co. Md.

18 (a) Funeral director Barron Thomas & Wright

(b) Address 727 Eutaw St

19 (a) NOV 16 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12th 1948 at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Nov 12 1948 and that I last saw h alive on Nov 11 1948

Immediate cause of death Cardiac Failure

Due to Cardiovascular disease. — Duration: 3 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature A. C. Burwell M. D.

Address 721 Eutaw St Date signed 11-15-48

68593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68593

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3407 Woodbrook Ave

(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3407 Woodbrook Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mollie Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1879

8. AGE: Years 69 | Months | Days | If less than one day: hr. | min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Morris

13. Birthplace Russia

MOTHER

14. Maiden Name Etta

15. Birthplace Russia

16 (a) Informant Samuel Schwartz

(b) Address 3407 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 210 Eutaw Place

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15-1948 at 4H M

21. I certify that death occurred on the date above stated, that I attended deceased from 1943 to 11-14 1948.

and that I last saw h alive on 11/14 1948

Immediate cause of death Acute Coronary Thrombosis

Duration 12 days

Due to General Coronary atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Owen Brown

Address 230 Eutaw Pl Date signed 11/15/48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 668594

668594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE PIVOWAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Morris Bratman
(b) Address 3816 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Old Fernwood Rd.

18 (a) Funeral director Jack Levi Inc
(b) Address 2100 Eutaw Place

19 NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1948, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1944 to 11-15 1948.
and that I last saw her alive on 11-15 1948.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 11-15-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

68595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 68595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S. Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 S. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Sierak

3 (b) If veteran, name war

3 (c) Social Security Account No. 215093315

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Phyllis Sierak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day hr.	min.
56				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Joseph Sierak
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Sipniewska
15 Birthplace Poland

16 (a) Informant Phyllis Sierak
(b) Address 706 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral Director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

NOV 16 1948 (Date rec'd by Registrar) Huntington Williamsville (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 48 to Nov 14 1948, and that I last saw h[e] alive on Nov 14 1948

Immediate cause of death Hypostatic Pneumonia — Duration 11/11/48
Due to Carcinoma of prostate — 3/1/48
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at (M)
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Groarke
Address 801 N Kenwood Ave Date signed 11/15/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140C

Registered No. 668596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Pennsylvania Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city limits, give name of township or other subdivision and of adjacent incorporated town)
(d) Street No. 2224 Pennsylvania Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAYBELLE NICHOLAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1919

8. AGE: Years 29 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George A. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Jones
15. Birthplace Maryland

16 (a) Informant Mr. Robert Micholas
(b) Address 2224 Penna. Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location A. A. Co., , Maryland

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle Street

19 NOV 16 1948 (a) Date rec'd by registrar (b) Huntingtown, Williamsville, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute generalized peritonitis due to infected abortion --- self induced

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Where (at work)?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 11-15-48

X

68597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3525 Keswick Road
(c) Hospital or institution: 13-06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Keswick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Virginia Slimmer.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Thomas J. Slimmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1865

8. AGE: Years	Months	Days	If less than one day
83	—	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER 12. Name A. H. Engle
FATHER 13. Birthplace New Jersey.

MOTHER 14. Maiden Name Sarah E. Grady.
MOTHER 15. Birthplace New Jersey.

16 (a) Informant Jay F. Slimmer.
(b) Address 2227 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road.

18 (a) Funeral director Eustace E. Sorrow
(b) Address 3438 Poland Ave.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948 at 1 45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948. to Nov. 13 1948 and that I last saw her alive on Nov. 13 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic C.V. Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund S. Hassman M.D.
Address 4027 Falls Rd Date signed 11/15/48

VS 150

X

68598

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 68598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 Boyle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Boyle St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY VOGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Adam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 15, 1863

8. AGE: Years	Months	Days	If less than one day
85	5	28	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Pipka
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline (Unknown)
15. Birthplace Germany

16 (a) Informant Catherine Vogel
(b) Address 1435 Boyle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A.County, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) 11/16/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 19 , at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 11-13 1948.
and that I last saw h alive on 11-13-48 19

Immediate cause of death — Duration
Bronchopneumonia
Due to
Due to
Other Conditions
CERTIFICATION APPROVED BY
Thomas J. Turnbull, M.D.
for Wm. J. Hagerich
CHIEF OR ASST. MEDICAL EXAMINER
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Denis J. McGrath, M.D.
Address 1E. Randall St. Date signed 11/15/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68599

BALTIMORE CITY HEALTH DEPARTMENT G68599 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Wilson St. Marlborough Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SOLOMON KATTEN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fannie Katten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1879.

8. AGE: Years 69 | Months 68 | Days 9 | If less than one day: hr. 15 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clothing Salesman.
11. Industry or business The Hub.

FATHER
12. Name Selig Katten,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Fannie Katten,
(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Abrie Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th. 1948 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/1936 to 11/15/1948 and that I last saw h[illegible] alive on 11/15/1948.

Immediate cause of death: Coronary Occlusion — Duration: Several hours.
Due to:
Due to:
Other Conditions: Coronary Sclerosis — Duration: About 5 years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address 11 E. Chase St. Date signed 11/16/48

VS 150

668600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668600 Registered No. 1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Woodbourne ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Woodbourne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Muhly

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-0954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Rose M. Beckmann
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Apr. 12 1876

8. AGE: Years	Months	Days	If less than one day
72	7	3	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired

FATHER
12. Name Christian Muhly
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Bowers
15 Birthplace Md

16 (a) Informant Mrs. William H. Muhly
(b) Address 905 Woodbourne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 1948 (month) (day) (year)
(c) Cemetery or crematory St Pauls Evangelical Lutheran
Location Violetville, Balto. Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address 4905 York Rd Huntington (Huntington or Williamsport, Md.)

19 (a) NOV 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/48 19 . at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6/1943 19 . to 11/15/ 19 48, and that I last saw him alive on 11/14/ 19 48.

Immediate cause of death	Duration
Uraemia	3 days
Due to Generalized arterio-sclerosis. Chronic nephritis.	? yrs.
Due to	
Other Conditions Prostatic hypertrophy benign. Asthma.	? yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B Yarrell M D
Address 11 E. Chase Sts. City Signed 11/16/48

VS 150

Please type or especially important. Physicians: please write the causes of death clearly and legibly.

GC8601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GC8601 Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 N ROSE ST.
(c) Hospital or institution: 6 W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 N ROSE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT W. ESLER.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LOUISE M

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) DEC. 6 - 1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	11	8		

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business RETIRED

FATHER
12. Name JOHN ESLER
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name CECILIA HAMIL
15. Birthplace BALTIMORE

16 (a) Informant LOUISE M. ESLER.
(b) Address 430 N ROSE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 17 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4300 BELAIR RD

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

19 (a) NOV 20 1948 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 14 1948 at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1948 to 11-14-1948, and that I last saw him alive on 11-14-1948

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	3 DAYS
Due to HYPERTENSION	6 YRS
Due to	
Other Conditions PREVIOUS CEREBRAL HEMORRHAGE WITH PARALYSIS (Include pregnancy within 3 months of death)	6 YRS.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Benj. B. Mosby M.D. M. D.
Address 448 N. Eutaw Ave Date signed 11-15-48

668602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 Forrest St.
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Forrest St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Hannah Bell~~ Annie Darby (Williams)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Wm J. Jackson

(b) Address 846 Penna Ave

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Washington Village Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/48 19 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to 11/14/48 19 ; and that I last saw h alive on 11/14/48

Immediate cause of death Chronic Myocarditis — Duration

Due to Chronic Nephritis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Thomas M. D.

Address 702 Edmondson Date signed 11/15/48

VS 153

668603 BALTIMORE CITY HEALTH DEPARTMENT 668603 Registered No.

CERTIFICATE OF DEATH 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 735 Puice St
(c) Hospital or institution:
17 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Puice St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca Thomas.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles Thomas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 26, 1902

8. AGE: Years: 45 | Months: 11 10 | Days: 1st | If less than one day: hr. min.

9. Birthplace New Castle, Delaware (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Howard.
13. Birthplace New Castle Del.

MOTHER
14. Maiden Name Sarah Waters.
15. Birthplace New Castle Del.

16 (a) Informant Dorothy Sams.
(b) Address 644 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie Williams
(b) Address 322 N Schroeder St

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1948 at 8, 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jun 3 1948 to Nov. 3 1948 and that I last saw he alive on Nov 3 1948.

Immediate cause of death Pul. tuberculosis

Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature W H Watts M. D.
Address 513 Irvington Date signed 11 16 48

VS 150

Type or write plainly, please. Write the cause of death clearly and legibly.

68604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓

Registered No. 68604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 1607
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/17

8. AGE: Years 67 | Months 7 | Days 30 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto. Transit

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Record - Mercy Hosp

(b) Address Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)

(c) Cemetery or crematory Olivet

Location St. Michaels, Md

18 (a) Funeral director Norman L. Marshall

(b) Address St. Michaels, Md

19 NOV 16 1948 (Date received by registrar) (By) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1948, at 2 30/P M

21. I certify that death occurred on the date above stated; that I attended deceased from N-8 1948, to 11-16 1948, and that I last saw h s alive on 11-16 1948.

Immediate cause of death: Myocardial failure — Duration: 8 days

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Benj Powell, Jr M. D.

Address Mercy Hosp Date signed 11-16-48

VS 130

G68605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G68605

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 McCulloh St
(c) Hospital or institution: 11 04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 McCulloh St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. BRISTOL

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/23/1926

8. AGE: Years 22 | Months 6 | Days 20 | If less than one day hr. min. 19

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business Arab Business

FATHER
12. Name James H. Edwards
13. Birthplace N.C.

MOTHER
14. Maiden Name Magaret Michael
15. Birthplace N.C.

16 (a) Informant Margaret Bristol (M)
(b) Address 917 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 NOV 16 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12th 1948 at 1:A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-5 1948 to 11-12 1948 and that I last saw him alive on 11 11 1948

Immediate cause of death: Broncho-Pneumonia — Duration: 7 Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed 11-15-48

VS 150

668606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

668606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Abt. 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 S. Fremont Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL HERMAN (MENKE) MEINKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Cordelia Meinke
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 25, 1881

8. AGE	Years	Months	Days	If less than one day
	67	0	20	hr. min.

9. Birthplace Cleveland, Ohio (Town, county, and state)
10. Usual Occupation Salvation Army
11. Industry or business

FATHER
12. Name Herman Meinke
13. Birthplace Germany

MOTHER
14. Maiden Name ? Ellger
15. Birthplace Germany

16 (a) Informant Records Salvation Army
(b) Address 925 S. Fremont Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Maryland

18 (a) Funeral director STEWART MOWEN CO.
(b) Address 108 W. North Avenue

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1948, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 11-15-48

VS 181

668607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 668607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Miss. (b) County
(c) City or town Lewis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 Front St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ARCHIE STARVIS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1895

8. AGE:	Years	Months	Days	If less than one day
	? 53			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Fisherman

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Adelaide Starvis

15. Birthplace ?

16 (a) Informant Records

(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 11-16-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn.
Location W. Baltimore

18 (a) Funeral director A. Polakoff

(b) Address 918-North Ave

19 NOV 16 1948 (b) Registrar Lucy Livingston Williamson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1948, at 11:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Nov. 11 1948, and that I last saw him alive on Nov. 11 1948.

Immediate cause of death	Duration
1- Nephrosclerosis with uremia	Unknown
2- Cardiac hypertrophy	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/12/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G68608

AB-122697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G68608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13-08
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Millrace Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Butler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married-Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 25- 1902

8. AGE: Years	Months	Days	If less than one day
45	11	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Walter Butler
13. Birthplace Virginia

MOTHER
14. Maiden Name Lulu Rider
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Manga
Location Hampden.

18 (a) Funeral director Paul C. Schumacher & Sons.
(b) Address 2116-18 Chestnut Ave.

19 (a) NOV 16 1948 (Name of registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15- 1948, at 8.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4- 1948, to 11-15- 1948, and that I last saw him alive on 11-15- 1948.

Immediate cause of death: Uremia. — Duration 4 wks.
Due to chronic glomerulo nephritis. — Duration ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature William H. Vanden Jr.
Address Balto City Hosp Date signed 15 Nov 48

Name not to be typed or printed. Physicians: please write the causes of death clearly and legibly. Cause of death is especially important. Please answer every question. Do not leave any space blank.

68609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 1307
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Chestnut Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA SUSAN BUTCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles W. Butcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1873

8. AGE: Years	Months	Days	If less than one day
75	2	9	hr. min.

9. Birthplace Tawneytown, Carroll Co., Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stanfield Fisher
13. Birthplace Carroll, Co., Md.

MOTHER
14. Maiden Name Sarah Rowe
15. Birthplace Carroll Co., Md.

16 (a) Informant Helen Williams (Daughter)
(b) Address 3712 Chestnut Avenue

17 (a) Burial (b) Date thereof 11-18-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laudon Park
Location Frederick Road

18 (a) Funeral director PAUL E. CHENOWITH, Jr.
(b) Address 3615-17 Chestnut Avenue

19 (a) NOV 16 1948 (b) Huntington Hill. Baltimore, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1948, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Boyer M.D.
Medical Examiner
Date signed 11-15-48

VS 191

68610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 7-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Roland Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard B Ball

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7147

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1901

8. AGE: Years 47 | Months 10 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Wm. E. Hooper

FATHER
12. Name John L. Ball
13. Birthplace ? Md.

MOTHER
14. Maiden Name Alice M. Ball
15. Birthplace ? Md.

16 (a) Informant: Carlton L. Haynes
(b) Address 1133 Roland Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's.
Location Hampden

18 (a) Funeral director Paul C. Schumacher
(b) Address [redacted] Chestnut Ave.

19 (a) NOV [redacted] (b) Huntington Williams M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13th 1948, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury

23. Signature William J. Stefreck M.D.
Medical Examiner.

Date signed Nov 13, 1948

VS 151

X

668611

Dr. Sunday
201 E. 33rd St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 Sinclair Lane
(c) Hospital or institution: 8 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Klein, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Alice T. Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1888

8. AGE: Years	Months	Days	If less than one day
60	10	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Engineer, B. & O. R.R.
11. Industry or business

FATHER
12. Name George Klein
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Eckmeyer
15 Birthplace Md.

16 (a) Informant Mrs. Alice T. Klein
(b) Address 2017 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 12.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 3 1948 to NOV. 15 1948 and that I last saw him alive on NOV. 15 1948

Immediate cause of death	Duration
ACUTE PULMONARY EDEMA	3 HOURS
Due to ARTERIO SCLEROTIC HEART DISEASE	3 YEARS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City, town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place (Specify) While at work?
(e) Nature of injury

23. Signature Stuart D. Sunday M.D.
Address 201 E. 33rd St. Date signed 11/16/48

68612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

68612 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2124 N. Charles St.

(c) Hospital or institution: Doctors Hosp. If not in hospital or institution, give residence.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1711 Orlando Road (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Carroll Hall - -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M -	W	d.

6 (b) Name of husband or wife Florence I Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-1887

8. AGE: Years 61 | Months 5 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace St. Mary Co. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Wm. T. Hall

13. Birthplace Md

MOTHER 14. Maiden Name Mary S. Tippett

15. Birthplace Md

16 (a) Informant Mrs. Ethel Hellwig

(b) Address 3101 Du Bois Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Balto

18 (a) Funeral director E. J. Luck

(b) Address 5205 Radford Rd

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15- 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948, to Nov 15 1948, and that I last saw h[illegible] alive on 11-15 1948.

Immediate cause of death — Metastatic Carcinoma of Liver & Stomach — Duration 4 mos.

Due to Primary Ca Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Richard Lowe Jr. M.D.

Address 5205 Radford Rd Date signed 11-15-48

VS 150

Spec.—8-24-16—M. & T.—2000 Blks.

668613 HEALTH DEPARTMENT—CITY OF BALTIMORE 668613

CERTIFICATE OF DEATH. 937

1-PLACE OF DEATH Kenesaw Nursing Home REGISTERED NO. C

CITY OF BALTIMORE: (No. 2601 Roslyn Avenue ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Victoria Tilghman

(Residence in Baltimore: No. 2601 Roslyn Avenue St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widowed

6-DATE OF BIRTH, July 7 (Month) (Day), 1866 (Year)

7-AGE, 82 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Samuel Norman

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Susannah Pindell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ada R. Bierbower

(Address) Blackstone, Va.

15- NOV 16 1948 Huntingtown Williamsville, Md.
Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 14 (Day), 1948 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 16 1948, to November 14 1948, that I saw h[er] alive on November 14 1948, and that death occurred, on the date stated above, at 8:55 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. O. Bellman M. D.

Nov 14, 1948 (Address) 60 Baltimore Ave Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery, Balto. DATE OF BURIAL, Nov. 16, 48

20-UNDERTAKER John O. Mitchell & Sons, Inc. ADDRESS 1900 Eutaw Pl.

per Malcolm B. Mitchell

C68614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. C68614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: I626 Holbrook Street
(c) Hospital or institution: 9 cy
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): 21 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: I626 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: John F. Beck

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 215-I6-0345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margie A. Hooper
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Dec. I4th., I898

8. AGE: Years	Months	Days	If less than one day
49	II	0	######### min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual Occupation: Guard

11. Industry or business: Detective Agencies

FATHER
12. Name: Michael J. Beck
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Ada V. Bunch
15. Birthplace: Baltimore County, Md.

16 (a) Informant: Mrs. Margie A. Beck (Wife)
(b) Address: I626 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof:** II/I7/48 (month) (day) (year)
(c) Cemetery or crematory: Fork Christian Church Cem.
Location: Fork, Balto. Co. Maryland

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: I735 Harford Avenue

19 (a) NOV 16 1948 (Date rec'd by registrar) **(b)** Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November I4th 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Nov. 14 1948, and that I last saw him alive on Nov. 14 1948.

Immediate cause of death: Heart Failure — Duration: 2 days
Due to: Myocardial Insufficiency — 4 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Loy M. Zimmerman M. D.
Address: 2050 Harford Rd. Date signed: Nov. 15, 48

Loy M. Zimmerman

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 68615

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 wk

(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 4800 Wrenwood Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: ERNEST JOSEPH SCHULTZ

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: yes- ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Hilda Schultz

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	24	hr. min.

9. Birthplace: So. Dakota (Town, county, and state)

10. Usual Occupation: Storekeeper gauger

11. Industry or business:

FATHER

12. Name: ?

13. Birthplace:

MOTHER

14. Maiden Name: ?

15. Birthplace:

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-18-48 (month) (day) (year)

(c) Cemetery or crematory: Balto. National

Location: Frederick Rd

18 (a) Funeral director: John A. Moran

(b) Address: 3006 E. Balto St.

19 (a) NOV 16 1948 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1948 at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1948 to Nov. 15 1948 and that I last saw him alive on Nov. 15 1948.

Immediate cause of death: Carcinoma of stomach with perforation and peritonitis — Duration: unkn

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: David D. LeGrand 5:35 PM

David D. LeGrand M. D.

Address: US Marine Hospital Date signed: 11/15/

VS 150

G68616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1202

Registered No. G68616

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd. & Calvert

(c) Hospital or institution: Union Memorial Hosp. 9-01

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 622 Wyndale Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Thomas Bailey Swanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1930

8. AGE: Years	Months	Days	If less than one day: hr.	min
18	3	26		

9. Birthplace Balt., Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER — 12. Name Hartwig A. Swanson

13. Birthplace Sweden

MOTHER — 14. Maiden Name Edythe Styles

15. Birthplace Balt., Md.

16 (a) Informant Parents

(b) Address 622 Wyndale Ave., Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd.

18 (a) Funeral director John R. Moran

(b) Address 3000 E. Balto St.

19 (a) (Date received by registrar) NOV 18 1948 (Registrar's signature) Investigator (Initials only)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22, 1948 to Nov. 14, 1948 and that I last saw h in alive on Nov. 14, 1948

Immediate cause of death Toxemia

Duration 5 wks.

Due to Ulcerative colitis, acute

Duration 5 wks.

Due to

Other Conditions G.I. Amoebiasis

(Include pregnancy within 3 months of death)

Date of operation 11-9-48

Major findings of operation: Ulcerative colitis

of autopsy: Ulcerative colitis + amoebiasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature M. F. Coyne M.D.

Address Union Memorial Hosp. Date signed 11-14-48

VS 199

G68617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G68617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Melrose Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. PADGETT, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-5834

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
21				

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Service Station

FATHER 12. Name Wm. J. Padget, Sr.
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Reynolds
15. Birthplace Maryland

16 (a) Informant Mr. J. Padgett, Sr.
(b) Address 34 Melrose Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John R. Moran
(b) Address 3040 E. Balto. St.

19 (a) Nov 16 1948 (Date) rec'd by registrar (b) Signature of Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948 at 6:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 11-12-48 at 11:35 P. M.
(b) Where did injury occur? Joppa Road, 400' east of Black & Decker Entrance - Balto. Co.
(c) Did injury occur at home, on farm, industrial place, or in public place? Public (What) No
(d) Means of injury Auto. & Auto. Collision

23. Signature Earl L. Rogers Medical Examiner M.D.
Date signed 11-15-48

VS 151

G68618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G68618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6042 Yorkshire Drive
(c) Hospital or institution: 27-08

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6042 Yorkshire Dr (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Cecelia Parsons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Marion S. Parsons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1873

8. AGE: Years 75 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Morgreth
13. Birthplace Germany

MOTHER 14. Maiden Name Dorothy Mache
15. Birthplace Germany

16 (a) Informant Mrs Mary Lorsen
(b) Address 6042 Yorkshire Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Baltimore St.

19 (a) NOV 16 1948 (Date received by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948, at 2:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Nov 15 1948, and that I last saw her alive on Nov 15 1948.

Immediate cause of death Lobar Pneumonia (TERMINAL) — Duration 2 days

Due to Lymphosarcoma — 15 yrs

Due to Cardiovascular Renal Disease — 0

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick V. D. Wood M. D.
Address 513 E. 39th St Date signed Nov 16

VS 100

X

68619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 Spring Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and name town)
(d) Street No. 243 Spring Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** King Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Quinn

6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Dec. 25-1880

8. **AGE:** Years: 67 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Greenville S. C.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Bob. Quinn
13. Birthplace: Greenville S.C.

MOTHER
14. Maiden Name: Julia ?
15. Birthplace: Greenville S.C.

16 (a) Informant: Mattie Quinn
(b) Address: 243 Spring Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 17-48
(month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem
Location: Brooklyn Md.

18 (a) Funeral director: Leroy O. Wilson
(b) Address: 1010 Bentley ave.

19 (a) NOV 16 1948 (b) Center for Philadelphia, Pa.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Nov 14 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-12 1948 to 11-14 1948, and that I last saw him alive on Nov 13 1948.

Immediate cause of death: Arteriosclerotic heart disease

Duration: unknown

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: G. C. Burrell M. D.
Address: 1711 Argyle Date signed: 11-15-48

VS 150

X

G68620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2211 W. Rogers Ave.
(c) Hospital or institution: Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 mo 15
(e) Length of stay in Baltimore (yrs., mos., or days): 74

7. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: VILLA SAUNDERS SHAW

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife: Eben S. D. Shaw
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1864

8. AGE: Years	Months	Days	If less than one day
84	3	15	hr. min.

9. Birthplace: Nova Scotia, Canada (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: William Saunders
13. Birthplace: Nova Scotia, Canada

MOTHER
14. Maiden Name: Teuruah Patten
15. Birthplace: Nova Scotia, Canada

16 (a) Informant: Miss Miriam O. Coates, Supt.
(b) Address: Home for the Aged of the Meth. Ch. 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15, 1948 at 2:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 15 1948 and that I last saw her alive on Nov 14 1948.

Immediate cause of death: Coronary thrombosis — Duration: 4 hours
Due to: Arterio Sclerosis — 20 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Arthur F Lanier M. D.
Address: 800 N 32nd Date signed: 11-15-48

VS 130

68621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68621 Registered No. ✓ X 8 2a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rockdale (If outside city or town limits, write RURAL and give town)
(d) Street No. Mayfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William J. Goode

3 (b) If veteran, name war –

3 (c) Social Security Account No. 212-10-2956

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marguerite Goode
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 10, 1907

8. AGE: Years	Months	Days	If less than one day
41	2	5	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business WBAL

FATHER
12. Name Wm. B. Goode
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Strong
15. Birthplace N. Y.

16 (a) Informant Mrs. Marguerite Goode
(b) Address Mayfield Ave., Rockdale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1948, to Nov 15 1948, and that I last saw him alive on Nov 15 1948.

Immediate cause of death: Intracranial Hemorrhage — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Benson MD
Address 1401 Hoyt Date signed 11/15/48 (M/D)

John F. Benson

VS 150

G68622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Springdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 - 07

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BENJAMIN A. DUVALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Edith W. Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 17, 1876

8. AGE: Years	Months	Days	If less than one day
72	7	28	hr. min.

9. Birthplace Croome, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. E. Duvall
13. Birthplace Croome, Md.

MOTHER
14. Maiden Name Mariah Bourne
15. Birthplace Md.

16 (a) Informant Miss Ellen N. Duvall
(b) Address 4407 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem.
Location Croome, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto, Md. for Williams, Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Nov 15 1948. and that I last saw alive on Nov 15 1948

Immediate cause of death	Duration
Coronary Occlusion	1 hr.
Due to Generalized Arteriosclerosis (a)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos J Robertt M. D.
Address 4509 Liberty Heights Date signed

VS 150

G68623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G68623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home 2 1-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY B. BOWEN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 17, 1862

8. AGE: Years	Months	Days	If less than one day
86	6	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pullman Conductor, retired
11. Industry or business

FATHER
12. Name George W. Bowen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Baltimore

16 (a) Informant Mrs. Fonsia Weller
(b) Address 2107 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 7:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948. to Nov 15 1948. and that I last saw h in alive on Nov. 13 1948.

Immediate cause of death Myocarditis — Duration years

Due to Arterio-Sclerosis generalized — years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Hermann M. D.
Address 702 E. Preston St. Date signed 11/16/48

VS 130

X

G68624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G68624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Wyman Pkwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Wyman Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY MARTYN WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-16-5152

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Roberta White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	24	hr. min.

9. Birthplace Lexington, Va.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business North American Oil Co.

FATHER
12. Name Thomas Spottswood White
13. Birthplace Lexington, Va.

MOTHER
14. Maiden Name Sarah Ellen Cameron
15. Birthplace Lexington, Ky.

16 (a) Informant Mrs. Anna R. White
(b) Address 2904 Wyman Parkway

17 (a) Burial (b) Date thereof 11/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (b) Huston Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 2:15 P M

21. I certify that death occurred on the date above stated that I attended deceased from June 15 1948 to Nov. 15 1948 and that I last saw h/ alive on Nov. 15 1948

Immediate cause of death	Duration
Cerebral thrombosis	
Due to arteriosclerotic Heart Disease	
Due to	
Other Conditions generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M.D.
Address 6 E. Eager Street Date signed 11-16-48

VS 150

Medical Examiner's Case

Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68625

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1126 Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-5-76

8. AGE: Years	Months	Days	If less than one day
72	10	29	hr. min.

9. Birthplace Trinidad (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Walter Lawrence

13. Birthplace Trinidad

MOTHER

14. Maiden Name Elma McGuire

15. Birthplace Trinidad

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 9 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 10 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948 at 1-03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1948 to 11/3 1948 and that I last saw h alive on 19

Immediate cause of death

Due to Shock, hypoglycemia pulmonary edema smoke poisoning

Due to

Other Conditions H As CVD Syphilis & Acute Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Duration

Underline the cause to which death should be charged statistically.

Was autopsy? Yes about.

22. If death was due to external causes (violence) fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence Howard J. Madden M.D.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm Wilkins

Address J. H. Hosp Date signed 11/9/48

CERTIFICATE APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

VS 80

66C

G68626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G68626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 N. Hilton St.
(c) Hospital or institution:

15-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN Stewart WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Howard O. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	6	1	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Henry Stewart
13. Birthplace N. C.

MOTHER
14. Maiden Name Caroline
15. Birthplace N. C.

16 (a) Informant Mr. Howard O. Wright
(b) Address 2615 N. Hilton St.

17 (a) Burial (Entombment)
(Burial, cremation, or removal)
(b) Date thereof 11/18/48
(month) (day) (year)
(c) Cemetery ~~Crematory~~ Lorraine
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 NOV 16 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed

VS 151

68627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

68627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 E. Lanvale St.
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES G. BARE, JR

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Frances L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Aug. 30, 1903

8. AGE: Years	Months	Days	If less than one day
45	2	16	hr. min.

9. Birthplace: Augusta Co., Va. (Town, county, and state)
10. Usual Occupation: Meat Cutter
11. Industry or business: State Meat Market

FATHER
12. Name: James G. Bare
13. Birthplace: Va

MOTHER
14. Maiden Name: Lydia Kelly
15. Birthplace: Va

16 (c) Informant: Mrs. Frances L. Bare
(b) Address: 1006 E. Lanvale St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Thornrose
Location: Staunton, Va.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington & Williams Mortuary Inc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 19 , at 10:AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1948 to 11-16 1948, and that I last saw him alive on 11-15- 1948.

Immediate cause of death: Malignant Tumor of left kidney — Duration:
Due to Metastatic tumor to lungs & Brain
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury (Specify type of vehicle)
23. Signature L. W. Frantz M. D.
Address 1235 St Paul St Date signed 11-16-48

VS 150

X

668628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

668628 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 E. Chase St.
(c) Hospital or institution:
10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. BURKHARDT, SR

3 (b) If veteran, name war	3 (c) Social Security Account No.
World No 1	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 8, 1893

8. AGE: Years	Months	Days	If less than one day
55	7	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Self

FATHER
12. Name John Burkhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Valeria Lempka
15 Birthplace Germany

16 (a) Informant Mrs Anna H. Burhardt
(b) Address 1000 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A.County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 19 , at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/15 1948 and that I last saw him alive on 11/14/48 19

Immediate cause of death — Duration

Acute Cerebral Hemorrhage

Due to cerebral sclerosis

Due to Hypertension

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature A. L. Hornstein
Address 704 E. Biddle St Date signed 11/16/48 (M.D.)

VS 13C

68629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123 Registered No. 68629

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd, Ashdale

(c) Hospital or institution: Union Mem. Hosp 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 12

(d) Street No. 3333 North Charles (If rural give location)

(e) Citizen of foreign country? If yes, name country O (Yes or No)

3 (a) FULL NAME Clairart Parker Cowles — Clairart Parker Cowles

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 9, 1872

8. AGE: Years	Months	Days	hr.	min.
76	7	6	less than one day	

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation Professor, Geology

11. Industry or business Retired

FATHER

12. Name Alvin Cowles

13. Birthplace Iowa

MOTHER

14. Maiden Name Viola ?

15. Birthplace Iowa

16 (a) Informant Mrs. Janet Cowles

(b) Address 3333 North Charles

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem

Location

18 (a) Funeral director Wm. Cook Inc

(b) Address 217 St Paul St

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION 12:03

20. DATE OF DEATH 11-16 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1948, to 11-16 1948, and that I last saw h[illegible] alive on 11-16 1948

Immediate cause of death — Duration

Cerebral angiomatosis

Due to Arteriosclerotic heart disease & Generalized Arteriosclerosis

Due to

Other Conditions Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 9-27-48

Major findings of operation: Benign prostatic hypertrophy 10-16-48

of autopsy: [illegible]

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Mortimer Lee Williams M. D.

Address Union Mem. Hosp. Date signed 11-16-48

VS 150

68630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DO A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Tyson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BANKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

University Medical School NOV 15 1948
Commissioner of Health

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 31

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 7:45 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 11/6/48

068631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

Registered No. 068631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Henneman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Henneman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCES L. SCHUCH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married-separated

6 (b) Name of husband or wife William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1904

8. AGE: Years	Months	Days	If less than one day
44	4	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Bolek
13. Birthplace Unknown

MOTHER
14. Maiden Name Francis Ulilik
15. Birthplace Unknown

16 (a) Informant William J. Schuch
(b) Address 1120 N. Luzerne Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Schmunck Funeral Home Inc.
(b) Address 2601 E. Madison, St.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 1.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pelvic Peritonitis
Cystitis
Due to Malnutrition

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
(Medical Examiner)
Date signed November 15, 1948

VS 191

6332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 68632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5412 TRAMORE RD
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 TRAMORE RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET E. WALTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race M.

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ERVIN J. WALTER

6 (c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr) JAN 14, 1867

8. AGE: Years 81 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace TYASKIN, MD
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name JOHN W. JONES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ADELINE PORTER
15. Birthplace MARYLAND

16 (a) Informant MRS ROLAND MARSHALL
(b) Address 5412 TRAMORE RD

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory ST. MARYS P.E
Location TYASKIN MD

18 (a) Funeral director ULRICH FUNERAL HOME
(b) Address 2004 ORLEANS ST

NOV 17 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 16 1948 at 7:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from JUNE 1947 to NOV 1948 and that I last saw h[illegible] alive on NOV 12 1948.

Immediate cause of death Duration
Far advanced generalized arteriosclerosis
Due to & senility.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 527 Harford Road Date signed 11-16-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 68633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 McElderry St.
(c) Hospital or institution:

7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/1900

8. AGE: Years 48 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name David Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Cora ?
15. Birthplace Va.

16 (a) Informant Mamie Williams
(b) Address 1602 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 11/18/48

(c) Cemetery or crematory Mt. Calvary
Location A.A. County

18 (a) Funeral director Lattie Gross
(b) Address 1408 Ashland Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma, Right Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or in public place? While at work?
(d) Means of injury

23. Signature John R Sears M.D.
Medical Examiner
Date signed 11/15/48

VS 151

G68634

AB -124630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109B

Registered No. G68634

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 331 Finch Ct. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John R. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 10-1945

8. AGE:

Years	Months	Days	If less than one day
3	9	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Taylor

13. Birthplace Virginia

MOTHER

14. Maiden Name Annie M. Allan

15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 21-48 (month) (day) (year)

(c) Cemetery or crematory Blanchet Cem

Location Petersburg Va

18 (a) Funeral director Elroy O Dickerson

(b) Address 1000 Brantley ave

19 NOV 17 1948 (Date rec'd by registrar) (b) Huntington Hdbg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948 at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1948 to 11-16 1948, and that I last saw h im alive on 11-16- 1948.

Immediate cause of death Pneumonia — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William P. Kean M.D.

Address Baltimore City Hospitals Date signed 11-16-48

VS 150

668635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 668635

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days): 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NJ (b) County:
(c) City or town: Wildwood (If outside city or town limits, write RURAL and give town)
(d) Street No.: 501 Tacony Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES HENRY DWYER

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 163-07-6863

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1894

8. AGE: Years: 54 | Months: 6 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: Fisherman

11. Industry or business:

FATHER
12. Name: Charles Henry Dwyer
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Julia A Toggweiler
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Fairview Cem.
Location: Cape May County, N. J.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1948 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1948 to Nov. 16 1948 and that I last saw him alive on Nov. 16 1948.

Immediate cause of death: Nephrosclerosis with hypertension and uremia — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury:

(b) Signature: C. F. van Ackeren, Medical Director M. D.
Address: Medical Officer in Charge Date signed 11/16/48

VS 180

688636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G688636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 North Exeter Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Mabel B. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6563

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: James Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1912

8. AGE: Years 36 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual Occupation: Laundress

11. Industry or business

FATHER
12. Name: Charles Butler
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Henrietta ?
15. Birthplace: Virginia

16 (a) Informant: James Holley
(b) Address: 135 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Charles R. Law
(b) Address: 802 Madison Ave

19 NOV 17 1948 (Date rec'd by registrar) (b) Huntington Hollins, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 9.15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural hemorrhage, compressing the brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 11/15/48

G8637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G68637

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3016 Wylie Ave

(c) Hospital or institution:

27-16

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3016 Wylie Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Sarah Faga Siegel

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Hyman

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business House Wife

FATHER

12. Name Joseph Lubowsky

13. Birthplace Russia

MOTHER

14. Maiden Name Gella ?

15. Birthplace Russia

16 (a) Informant Morris Siegel

(b) Address 3016 Wylie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 1948 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery

Location Southern Ave

18 (a) Funeral director: Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

(b) .....

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1948 to Nov. 17 1948, and that I last saw h[illegible] alive on Nov. 16 1948.

Immediate cause of death: Cerebral hemorrhage — Duration .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Benjamin Kadri M. D.

Address 2206 Eutaw [illegible] Date signed 11-17-48

VS 150

X

88638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G68638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Latrobe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Silas BURRELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-1869

8. AGE: Years	Months	Days	If less than one day
78 79	11	-	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jackson Burrell
13. Birthplace Virginia

MOTHER
14. Maiden Name Irene ?
15. Birthplace Virginia

16 (a) Informant Mrs. Mattie Phillips
(b) Address 1703 Latrobe St.

17 (a) Burial (b) Date thereof 11-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 17 1948
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 5.10a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Kyle M.D.
(Medical Examiner)
Date signed November 15, 1948

VS 151

68639 LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12B

Registered No. G68639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Elwood Avenue 16 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME EDMUND J. ZACHARSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-4931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/4/1900

8. AGE: Years	Months	Days	If less than one day
48	4	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edmund Zacharski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Hoppe
15. Birthplace Poland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ HOLY ROSARY
Location BALTIMORE CO, MD

18 (a) Funeral director George A Weber
(b) Address 705 South Arm st

19 NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/48 19 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/48 19 to 11/16/48 19 and that I last saw him alive on 11/16/48 19

Immediate cause of death For advanced pulmonary tuberculosis — Duration 6 mo.

Due to

Due to

Other Conditions Chronic alcoholism & vitamin deficiency — Duration years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M.D.
Address Balt. City Hospital Date signed 11-16-48

VS 150

68640

AD# 15958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 68640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 765 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Moody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife. Bertha (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 30- [illegible]886

8. AGE: Years	Months	Days	If less than one day
62	5	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Charles ?
13. Birthplace ?

MOTHER
14. Maiden Name Maria ?
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balt City

18 (a) Funeral director Isaiah T Brown Sr
(b) Address 126 W Montgomery St

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington-Williams Mt [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11- 1948 at 7.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6- 1936 to 11-11- 1948 and that I last saw him alive on 11-11- 1948.

Immediate cause of death Subarachnoid hemorrhage — Duration 4 days

Due to Arteriosclerotic vascular disease

Due to

Other Conditions Bronchopneumonia RUL. — one week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis Mearine M.D.
Address Balto City Hosp Date signed 11-15-48

VS 150

G68641

GM. 3827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12a

G68641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 S. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Kearney

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March -9-1877

8. AGE: Years 71 Months 9 Days 6 If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name James Kearney
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Lear
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18-1948 (mo., day, yr.)
(c) Cemetery or crematory New Cathedral
Location Balto City

18 (a) Funeral director Pott & B.M. Walker
(b) Address Pott & Chucker St

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 15 - 1948 at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 20- 1938 to 11- 15 1948. and that I last saw him alive on 11-15 1948

Immediate cause of death: Pneumoconiosis with secondary
Due to Far advanced Pulmonary Tuber -
Due to culosis
Other Conditions Chronic Obliterative Pericarditis
(Include pregnancy within 3 months of death)

Duration: 29 yrs

Date of operation —
Major findings of operation: —
of autopsy: above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed 11-20-48

VS 150

X

68642 AB- 124601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 68642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maude Heinerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife ? Bernard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25- 1881

8. AGE: Years	Months	Days	If less than one day
67	0	21	hr. min.

9. Birthplace Maryland (Town, County, and state)
10. Usual Occupation ? Saleslady
11. Industry or business Goodwill Industries

FATHER
12. Name James Riley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Fe
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Wm Cook Inc
(b) Address 217 S Paca St

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16- 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1948 to 11-16- 1948, and that I last saw her alive on 11-16- 1948

Immediate cause of death - Lymphatic Leukemia ?

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
MAY
none large
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. F. Nelson
Address BCH Date signed 11-19-48

BOARD OF PHYSICIANS FOR MEDICAL EXAMINER

VS 150

68643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 1685[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 32
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 468 Warwick St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence D Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife /

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1910

8. AGE: Years: 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name William [illegible]
13. Birthplace Va

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Va

16 (a) Informant Sarah Coles
(b) Address 468 Warwick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 48 (month) (day) (year)

(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) Dec 17 1948 (Date received by Registrar) (b) Registrar Washington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 noon 11/12 1948, to 1 am 11/12 1948, and that I last saw him alive on 11-12 1948.

Immediate cause of death: Renal Failure-Uremia — Duration

Due to Hypertensive cardio-vascular renal disease

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emerson C. Walden M. D.
Address Provident Hospital Date signed 11-14-48

VS 153

Please write the names of death clearly and legibly.

G68644 X ✓ G68644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNOR & DUNDALK Aves.
(c) Hospital or institution:
WEST BALTO. GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town DUNDALK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 LIBERTY PKWY.
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) **FULL NAME** William ARNholter

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNA V. ARNHOLTER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 22, 1904

8. AGE: Years	Months	Days	If less than one day
44	4	23	22 hr. min.

9. Birthplace SOUTH CAROLINA
(Town, county, and state)

10. Usual Occupation SUPERVISOR

11. Industry or business BAKERY

FATHER 12. Name GEORGE ARNHOLTER

13. Birthplace SOUTH CAROLINA

MOTHER 14. Maiden Name IODA

15. Birthplace SOUTH CAROLINA

16 (a) Informant ANNA V. ARNHOLTER

(b) Address 2603 LIBERTY PKWY.

17 (a) BURIAL (b) Date thereof NOV 18, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MARYLAND MEMORIAL

Location TAYLOR AVE., BALTO. CO. MD.

18 (a) Funeral director Roland L. Fisher

(b) Address 2112 DUNDALK AVE.

19 (a) ..... (b) .....
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 8:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 17 1948 to Nov 17 1948 and that I last saw him alive on Nov 14 48.

Immediate cause of death Acute Hemorrhagic pancreatitis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Acute hemorrhagic pancreatitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Leonard Tucker M.D.
M. D.

Address 1041 Baltimore Blvd Dundalk Md

Buried Nov 20 1948

Burlington Williamsville, Md

Nov 17, 1948

VS 150

Carefully and especially important. Physicians: please write the causes of death clearly and legibly. Be sure answer is complete. Do not abbreviate. Do not use terms of doubtful meaning. Be certain every item is correctly supplied. Use

AB- 123868 668645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45a

Registered No. 668645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or if not (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Maderia St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Schnader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband / wife George J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 7- 1883

8. AGE: Years	Months	Days	If less than one day
65	8	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Jacob Kattail (D
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Ahesser or Abesser (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location E. Northern Ave Ext

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b) Registrar
(Date received by registrar) Nov 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16- 1948, at 1.30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-19- 1948 to 11-16- 1948, and that I last saw h[illegible] alive on 11-16- 1948

Immediate cause of death: [illegible] Duration: Hours

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible], M.D.
Address 4940 Eastern Ave Date signed Nov 17 1948

VS 150

68646 BALTIMORE CITY HEALTH DEPARTMENT 68646
CERTIFICATE OF DEATH 477
Registered No. 44

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address — Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rosedale Box 31 (If outside city or town limits, write RURAL, and give town)
(d) Street No. Erney Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George V. Kouba, Sr. Kouba

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-6866

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948 at 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/8 1948, to 11/13 1948, and that I last saw h alive on 11/13 1948

Immediate cause of death — Cardiac failure
Due to Coronary thrombosis
Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

4. Sex M | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife Mrs. Elizabeth Kouba
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1891

8. AGE: Years 57 | Months 10 | Days 12 | If less than one day: hr min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation — Mechanic

11. Industry or business Self - employed

FATHER
12. Name Vincent Kouba
13. Birthplace Prague, Czechoslovakia (PRAGUE)

MOTHER
14. Maiden Name Elizabeth Az
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Kouba
(b) Address 672 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beland Rd

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave. Essex

19 (a) Nov. 17-48 (Date rec'd by registrar) (b) John B. Connelly (Registrar)
Huntington Williamsport, Md

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald W. Mintzer M.D.

Address Church Home Date signed 11/10/48

NOV 17 1948

Please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G68647 Registered No.

G68647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Forest St.
(c) Hospital or institution: 10+
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Forest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Philip Krasser

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of husband or wife: Mary Krasser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1866

8. AGE: Years	Months	Days	If less than one day
81	11	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cabinet Stable work
11. Industry or business Balto City Dept.

FATHER
12. Name Jacob Krasser
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Miller
15. Birthplace Germany

16 (a) Informant Mrs. J. C. Wagner (Niece)
(b) Address 1824 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Edward W. Conklin
(b) Address 924 E. Eager St.

19 (a) 11-19-1948 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 19 . to 11/13 19 48 and that I last saw h[illegible] alive on 11/13 19 48

Immediate cause of death — Duration

Acute Coronire Dilatation

Due to Ch Sclerosis

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 1104 E. Bradford St Date signed 11/16/48

Registrar

V S 130

G68648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G68648

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1016 Sterling St.

(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County More

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1016 Sterling St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lucy Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Joseph Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/17/04

8. AGE: Years	Months	Days	If less than one day
44	7	27	hr. min.

9. Birthplace Saxe, Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Henry Johnson

13. Birthplace Virginia

MOTHER

14. Maiden Name Unknown

15 Birthplace

16 (a) Informant Joseph Marshall

(b) Address 1016 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Baltimore, Maryland

18 (a) Funeral director Charles R. La...

(b) Address 802 Madison Ave.

19 (a) Huntington Williams, M.D. Registrar

(Date received by registrar) NOV 17 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 19 48 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 19 48 to 11/14 19 48.

and that I last saw h... alive on 11/14 19 48.

Immediate cause of death	Duration
Cardiac Failure	2 Hrs.
Cerebral Hemorrhage	3 Yrs.
Due to Hypertension	
Aortic Insufficiency	6 Yrs.
Due to Pulmonary Congest...	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Chas. R. Pittman

Address 802 Madison Ave Date signed 11/15/48

X

G68649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68649
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Montpelier Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HEIMILLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5655

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Sarah E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1881

8. AGE: Years 66 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Charles Heimiller
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Kerr
15. Birthplace Maryland

16 (a) Informant Mrs. Sarah Heimiller
(b) Address 1625 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948, at 12.15 P M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature L. J. Ruck M.D. (Medical Examiner.)
Date signed November 16, 1948

mp

VS 181

G68650 ✓ G68650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Bradway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Pinewood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME August Swanson

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married ~~widowed~~

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1872 - May 5

8. AGE: Years	Months	Days	If less than one day
76	6	11	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Swanson
13. Birthplace Sweden

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant self
(b) Address 3034 Pinewood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

NOV 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1948 to Nov 16 1948 and that I last saw him alive on Nov 16 1948.

Immediate cause of death Uremia — Duration 3 days

Due to Prostatic hypertrophy

Due to

Other Conditions bilateral hydronephrosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett, D
Address Church Home & Hosp Date signed 16 Nov 48

Form 150

68651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

✓ 68651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

25-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Hanover St. (S) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE E. COLEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1885

8. AGE: Years: 63 | Months: 2 | Days: 21 | If less than one day: hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Coleman
13. Birthplace New York City

MOTHER
14. Maiden Name Catherine Friel
15. Birthplace New York

16 (a) Informant: Louis Stein, Inc.
(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory St. Patricks
Location Cumberland, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

NOV 17 1948 (b) Registrar
(Date received by registrar) Lexington for Williams, MD

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 12:40PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 11/17/48

G68652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

G68652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution:
St. Joseph's Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 12yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. East Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Mabel Speca

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Married

6 (b) Name of husband or wife Frank Speca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1908

8. AGE: Years	Months	Days	If less than one day
40	1	15	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Hwie.
11. Industry or business none

FATHER
12. Name Carl A. Toney
13. Birthplace Dothan W.Va.

MOTHER
14. Maiden Name Winnie F. Thompson
15. Birthplace Plum Orchid W.Va

16 (a) Informant Frank Speca (Husband)
(b) Address 136 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20/48 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Dothan W.Va.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 (a) (b) Registrar
(Date received by registrar) Huntington Williams, MD

NOV 17 1948

VS 18)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/ 1948 to 11/16/ 1948, and that I last saw her alive on 11/16/ 1948

Immediate cause of death	Duration
Uremia	
Due to Arteriolar Nephrosclerosis	
Due to Hypertensive Cardio-Vascular Disease	
Other Conditions Congestive Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Geo. E. Simons Jr. M.D.
Address 22 E. Franklin St. Date signed 11/14/48

X

G68653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G68653
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: GENERAL GERMAN AGED PEOPLES HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. ATHOL AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ELIZABETH SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Lt. STONEWALL J.D. SCOTT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 15, 1868

8. AGE: Years 80 | Months — | Days 1 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant GENERAL GERMAN HOME
(b) Address 22 S ATHOL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 18 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 38 & FREDERICK AVE

18 (a) Funeral director Harry H Wilhelm
(b) Address 4401 Edmondson Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3.20

20. DATE OF DEATH NOV. 16 1948 at A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 2/48 19 ... to Nov. 16/ 1948. and that I last saw her alive on Nov. 14/ 1948.

Immediate cause of death	Duration
Broncho-Pneumonia	14 days.
Due to	
Due to	
Other Conditions: Unknown	
Arterio-Sclerosis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(c) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Hacks Tiemann M. D.
Address 723 Hamilton Ave Date signed Nov 17 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G68654
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabel L. Bosa

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-4900

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-12-04

8. AGE: Years 44 | Months 7 | Days 3 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business INTERNATIONAL HARVESTER

MOTHER / FATHER

12. Name Geo Geo Bosa

13. Birthplace Md

14. Maiden Name Pauline Strachfe

15. Birthplace New York

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 18 '48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Harry H Tyler

(b) Address 4101 Edmondson Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948 at 2 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948 to 11/15 1948 and that I last saw her alive on 11/15 1948.

Immediate cause of death: Carcinoma of the Breast with metastases — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 1948

Major findings of operation: Carcinoma left breast

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Handelsman M. D.

Address Johns Hopkins Hosp Date signed Nov 15, 1948

G68655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G68655 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 Harlem Ave.
(c) Hospital or institution None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 83-3-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa C. Schange

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George L. Schange

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1865

8. AGE: Years 83 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Conrad Neidhardt

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Mary Lehr

MOTHER 15. Birthplace Germany

16 (a) Informant Miss Marie E. Schange

(b) Address 2321 Harlem Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave. Balto.

18 (a) Funeral director Easton Jones

(b) Address 608 Frederick Ave. Catons

NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 7:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 15 1948 and that I last saw her alive on Nov 15 1948.

Immediate cause of death Carcinoma of lung metastatic to lung Ca of breast — Duration

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr 1941

Major findings of operation: Ca of breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hab Bender M.D.

Address 1517 E North Ave Date signed 11/16/48

VS 150

BC-DD-2063 668656

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 668656

CERTIFICATE OF DEATH

81a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University 12 + 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 744 Reservoir St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Ann Ladnier

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 25, 1948

8. AGE: Years | Months | Days | If less than one day: hr min.
7 | weeks 2 |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Charles Ladnier
13. Birthplace Alabama.

MOTHER
14. Maiden Name Ann Shields
15. Birthplace Pennsylvania

16 (a) Informant Mother
(b) Address 744 Reservoir St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Mt Auburn Pennsylvania

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) Date received by registrar NOV 19 1948 (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1948 at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 16 1948 and that I last saw her alive on 11/16 1948.

Immediate cause of death: Respiratory Paralysis — Duration: 2 hrs. (?)
Due to E. Coli meningitis
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Pheneland Jr. M.D.
Address University Hosp. Date signed 11/16/48

VS .139

G68657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G68657

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3911 Ridgecroft Rd. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa B. March

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife David S. March

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	9	8		

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Barger

13. Birthplace Virginia

MOTHER 14. Maiden Name Mollie Farris

15. Birthplace Virginia

16 (a) Informant James C. Harrison

(b) Address 3911 Ridgecroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams M.D. (Registrar)

(Date received by registrar) NOV 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Nov 15 1948 and that I last saw h[illegible] alive on Nov. 15 19 48

Immediate cause of death	Duration
INTESTINAL OBSTRUCTION	48 hrs.
Due to STRANGULATED. Rt. INGUINAL HERNIA	4 days.
Due to	
Other Conditions CEREBRAL ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)	10 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work)

(e) Means of injury

23. Signeture Norman R. Klemm M.D.

Address 3803 Edmondson Ave Date signed 11/17/48

68658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 68658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution: Beech Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Rodgers Forge (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHRISTINA SCHMIDT

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Adolph
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1868

8. AGE: Years: 80 | Months: 2 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Mueller
13. Birthplace: Geermany

MOTHER
14. Maiden Name: Christina (Unknown)
15. Birthplace: Germany

16 (a) Informant: Charles T. Mahan
(b) Address: 322 Dunkirk Road, Rodgers Forge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) Nov 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1948 19 at 11 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to Nov 18 1948, and that I last saw her alive on Nov 18 19 4

Immediate cause of death: Cardiac failure — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: [illegible] M.D.
Address: 6028 York Rd
Date signed 11/17/48 M D

VS 150

68659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4649 Harcourt Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4649 Harcourt Rd (If rural give location)
(e) Citizen of foreign country? — Yes or No
If yes, name country —

3 (a) FULL NAME Mary E. A. Coburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thos. H. Coburn

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Mar. 26. 1866

8. AGE: Years 82 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Talbot Co. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Q. Adams
13. Birthplace Talbott Co.

MOTHER
14. Maiden Name Ann M. Dulin
15. Birthplace Talbott Co.

16 (a) Informant Mrs. Anna Penn
(b) Address 4649 Harcourt Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18. 48 (Month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave Rd

18 (a) Funeral director L. Hemmann & Son
(b) Address 6067 Harford Rd

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15. 1948. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1948. to Nov 15 1948. and that I last saw her alive on Nov 15 1948

Immediate cause of death Chronic Myocarditis

Due to Arterio-sclerotic Cardio vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Thomas E. Hott, M.D.
Address 1331 E. North Ave Date signed 11-17-48.

VS 150

Medical Examiner's Case

8660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered (Medical)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Guilford ave #18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C WARD Jr. (HENRY (HARRY) CLAY WARD, JR.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lola M. Ward

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 24 1882

8. AGE: Years: 66 | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Retired Railroad worker

11. Industry or business

FATHER
12. Name: Henry C Ward Sr.
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Ella Hines
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Lola M. Ward
(b) Address: 2035 Guilford ave #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 18 1948 (Date received by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 15 1948, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11·9 1948, to 11·15 1948, and that I last saw him alive on 11·15 1948

Immediate cause of death: Cardio-Respiratory failure - following general anesthesia — Duration:

Due to: Arteriosclerosis

Due to: Diabetes Mellitus

Other Conditions: Inspected

CERTIFICATION APPROVED BY
Thomas T. Mackie, M.D.

(Include pregnancy within 3 months of death)

Date of operation 11·15·48

Major findings of operation: Pocket of pus under Scalp of foot

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: Nov. 15, 1948 at 11 A.M.
(c) Where did injury occur? Maryland General Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury: Administration of sodium Pentothal anesthesia

23. Signature: Richard L. Martin M.D.
Address: Maryland Gen. Hosp. Date signed 11/15/48 M. D.

To be approved by Medical Examiner

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 668661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 69 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1737 Ashburton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: DAVID CARRINGTON YOUNG

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Young

6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1874

8. AGE- Years: 74 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Carrington A. Young
13. Birthplace: DC

MOTHER
14. Maiden Name: Cornelia Hergesheimer
15. Birthplace: DC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 19 48, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 19 48 to Nov. 15 19 48, and that I last saw him alive on Nov. 15 19 48

Immediate cause of death: Carcinoma of urinary bladder — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: S.F. van Ackeren, Medical Director
Address: Medical Officer in Charge Date signed: 11/15/48

V S 150

Patients wife gave age & date of birth as: Feb. 26, 1873
75 yrs. 8 mos. 19 das.

Physicians: please write the causes of death clearly and legibly. Especially important.

G68662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

102

Registered No. G68662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everett Cornish

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1910.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38	2	24		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Construction

FATHER
12. Name Charles Cornish.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rosie Dimby.
15. Birthplace Baltimore Md.

16 (a) Informant Rosie D. Cornish.
(b) Address 741 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) Nov 18 1948 (Date received by registrar) (b) Huntington Williams, Met Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-48 19 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-15-48 19 to 11-16-48, and that I last saw h[illegible] alive on 11-16-48 19

Immediate cause of death	Duration
a Respiratory failure	
Due to Hypostatic Encephalopathy	
Due to Malignant Hypertension	
Other Conditions Uremia	

(Include pregnancy within 3 months of death.)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. Hahn M D
Address University Hosp Date signed 11-17-48

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68663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 68663

Please write information asked for carefully and correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otis Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Della Taylor.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1878.

8. AGE: Years	Months	Days	If less than one day
70	10	14	hr. min.

9. Birthplace Northumberland Co., Va. (Town, county, and state)
10. Usual Occupation Baker.
11. Industry or business

FATHER
12. Name Daniel Taylor.
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Northumberland Co. Va.

16 (a) Informant Della Taylor
(b) Address 515 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1948. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Theo Katen Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1948. at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1948. to 11-15 1948. and that I last saw h(M) alive on 11-13 1948.

Immediate cause of death Arterio Sclerotic Cardio Renal Disease — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St. Date signed 11-15-48

68664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 170c

Registered No. 68664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Freetown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KERMIT COATES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Otto Coates
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie Harris
15. Birthplace Maryland

16 (a) Informant: Otto Coates
(b) Address Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 48 (month) (day) (year)
(c) Cemetery or crematory Marley Marley Neck A A Co Md
Location

18 (a) Funeral director Israel L Brown Son
(b) Address 1086 Montgomery St

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Lentington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948, at 12.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull.
Intracranial hemorrhage.
~~Due to~~ Contusion of brain.
Terminal pneumonia.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-13-48 at 6.30 p. M.
(b) Where did injury occur? Sollers Rd. A.A. Co., Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury truck into ditch

23. Signature [illegible] M.D. Medical Examiner.
Date signed November 16, 1948

VS 181

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1 PLACE OF DEATH

Baltimore City, Maryland

b Street address

c Hospital or institution

d Length of stay in hospital or nsti yrs, mos, or days

e Length of stay in Baltimore yrs, mos, or days

2 USUAL RESIDENCE OF DECEASED

State

City or town

Street No

Citizen of foreign country?
If yes, name country

3 FULL NAME

HAE

4 Sex

5 If veteran, name war

6 Color or race

7 Single, married, widowed, or divorced

8 AGE Years Months Days If less than one day

9 Birthplace

10 Usual Occupation

11 Industry or business

MOTHER / FATHER

12 Name

13 Birthplace

14 Maiden Name

15 Birthplace

16 Informant

Address

17 Date thereof

Cemetery or crematory

Location

18 Funeral director

Address

19

MEDICAL CERTIFICATION

20 DATE OF DEATH

21

Immediate cause of death

BY WHAT

Date of operation

Major findings of operation

of autopsy

22 If death was not natural

Accident, suicide or homicide

a Date of occurrence

b

Manner of injury

Signature

Address

668666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

668666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Peters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29 1872

8. AGE: Years	Months	Days	If less than one day
76	1	19	hr. min.

9. Birthplace Bristol R.I. (Town, county, and state)
10. Usual Occupation Waterman
11. Industry or business Md. Life Ins. Co.

FATHER
12. Name Richard Peters
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Fogarty
15. Birthplace Ireland

16 (a) Informant Margaret Anne Peters
(b) Address 1610 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fisher & Sons
(b) Address 1827 W. North Ave. Huntington Williamsport Md.

NOV 18 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Nov 17 1948, and that I last saw him alive on Nov 15 1948.

Immediate cause of death	Duration
Coronary Thrombosis	11/17/48
Due to	
Due to Chr. Myocarditis	1947
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James Brown M. D.
Address 1631 N. Fulton Ave. Date signed 11/17/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

...ORE CITY HEALTH D... ...TION

CERTIFICATE OF D...TH 92

Please use ink or typewriter. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1750 HANOVER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 HANOVER ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD SIMON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY. SIMON
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) SEPT 3 - 1858

8. AGE: Years	Months	Days	If less than one day
90	2	13	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED BAKER
11. Industry or business

FATHER
12. Name CONRAD SIMON
13. Birthplace GERMANY.

MOTHER
14. Maiden Name SOPHIA. SCHROEDER.
15. Birthplace GERMANY.

16 (a) Informant MARY. SIMON (WIFE)
(b) Address 1750 HANOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV-20-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co

18 (a) Funeral director Bernard E. Hurle
(b) Address 121 E West St

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 16 1948 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Nov 16 19 48. and that I last saw h— alive on Nov 15 19 48.

Immediate cause of death Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Arteriosclerosis. Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

—

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Schrand
Address 1337 Schroeder St Date signed 11/19/48 M. D.

VS 150

668668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178c

668668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Grinald Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES M. WOOD, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Helen Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1908

8. AGE: Years 40 | Months 3 | Days 11 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Captain (Tugboat)

11. Industry or business Maryland Drydock

FATHER
12. Name Charles M. Wood, Sr.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Coppage
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Ruth Wood
(b) Address 1915 Grinald Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Edward Lowndes
(b) Address 2059 Wash. Blvd.

NOV 18 1948
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 7:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at ? A. M. 256
(b) Where did injury occur? Maryland Dry Dock, Fairfield
(c) Did injury occur at home, on farm, in industrial place, or public place? Industrial While at work? yes
(d) Means of injury Inhalation of carbon monoxide

23. Signature Earle Boyd M.D.
Medical Examiner.
Date signed 11-17-48

668669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S. George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kuntz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Mrs. Mary Kuntz
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr) 5-16-88

8. AGE: Years 60 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Surveyor
11. Industry or business

FATHER
12. Name Charles Kuntz
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Beecher
15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Wm Cook Co.
(b) Address 1217 St Paul St.

NOV 18 1948 (Date rec'd by registrar) Washington Williams M.D. (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948 to 11-17 1948, and that I last saw him alive on 11-17 1948.

Immediate cause of death: Carcinoma of Stomach with Metastases — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10-15-48

Major findings of operation: Carc. Stomach generalized peritoneal implant

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Handelsman
Address Johns Hopkins Date signed 11-18-48 M.D.

VS 150

G68670 C.F.P. 275 ✓ G68670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE CAMPBELL

3 (b) If veteran, name war —— | 3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife ——
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
5			hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation ——
11. Industry or business ——

FATHER
12. Name Leonard Agleston
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Edna Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Angest Gilbert
(b) Address 1607 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Anne Arundel, County

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount Street

NOV 18 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd and 3rd Degree Burns
85% body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P. M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, in factory, in public place? home While at work? No
(d) Means of injury Trapped in burning room

23. Signature P. J. Gilbertie M.D. (Medical Examiner)
Date signed 11/18/48

VS 151

G68671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180

G68671
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CARRIE CAMPBELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: 50 mnt | Months | Days | If less than one day: hr. min

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Louis R. Grant
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Isabella Anderson
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Agnest Gilbert
(b) Address: 1607 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem.
Location: Anne Arundel County, Md.

18 (a) Funeral director: Metropolitan Life Ins. Co.
(b) Address: 927 N. Mount Street

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

Nov 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: 2nd and 3rd Degree Burns 75% Body

Due to

Other Conditions: Internal chest injuries (Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P. M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: House afire--Jumped from 3rd floor window

23. Signature: Chas. Sulinski M.D. Medical Examiner.
Date signed 11/18/48

G68672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68672 ✓ Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: DAISY GRANT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife ———
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
42 amt			hr. min.

9. Birthplace Baltimore, (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Louis R. Grant
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Isabella Anderson
15. Birthplace Baltimore, Maryland

16 (a) Informant Agnes Gilbert
(b) Address 1607 Edmonson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Metropolitan Funeral Home, Inc.
(b) Address 927 N. Mount Street

19 (a) [illegible] (Date Rec'd by Registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P.M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury House fire--jumped from third flr. window

23. Signature [signature] M.D. Medical Examiner.
Date signed 11/18/48

G68673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

Registered No. G68673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 McKim St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 McKim St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carlyn Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25-1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	2	22		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name John N. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Balto. Md.

16 (a) Informant Carlyn Smith
(b) Address 833 McKim St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John H. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1948 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1948 to October 1948 and that I last saw h alive on October 17 1948.

Immediate cause of death Tuberculosis of lungs, laryngeal and intestine. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Truman M.D.

Address 623 E. N. Ave. Date signed Nov 18/48 M. D.

Physicians: please write the causes of death clearly and legibly. Be especially important.

G68674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G68674
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Tomaszewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Theodore Tomaszewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1874

8. AGE: Years	Months	Days	If less than one day
74	3	21	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Theodore Tomaszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Mrs. Valeria Sabalewski
(b) Address 619 S. Belnord ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary cemetery
Location Balto County

18 (a) Funeral director John J. McWeeney
(b) Address 402 S. Chester Street

19 (a) 11 18 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

430

20. DATE OF DEATH Nov 16 1948 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1948 to 11/16 1948, and that I last saw her alive on Nov. 15. 1948.

Immediate cause of death Senility

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
—
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond R. Nowak M. D.
Address 402 S. Patt. Oh Cem. Date signed 11/17/48

VS 3

G68675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G68675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Eastern ave
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Eastern ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette Rakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Walenty Rakowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1879

8. AGE: Years	Months	Days	If less than one day
69	7	20	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Antoni Jarzynski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Sabus
15. Birthplace Poland

16 (a) Informant Mrs Pauline Kasul
(b) Address 2703 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 402 S. Chester Street

19 (a) [illegible] 1948 (b) Clinton Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

935

20. DATE OF DEATH Nov 14 1948, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 19[illegible], to Nov. 14 1948, and that I last saw her alive on Nov. 14 1948.

Immediate cause of death Carcinoma of Liver & Biliary tract (Primary)

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 524 Eastern Date signed

VS 8

To be checked by chief Med Examiner

G68676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G68676

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division Street

(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore 9

(If outside city or town limits, write RURAL and give town)

(d) Street No. 408 Gold Street

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) **FULL NAME** Wright, Mary

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1867

8. AGE: Years	Months	Days	If less than one day
81 79	10 9	15	hr. min.

9. Birthplace Howard County, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Alexander Mace

13. Birthplace Howard Co. Md.

MOTHER

14. Maiden Name Louise Oliver

15. Birthplace Howard Co. Md

16 (a) Informant Mrs. Lena Major

(b) Address 408 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 19 48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mr. Earl Gilmore

(b) Address 519 N. Monroe St.

19 (a) NOV 18 1948 (mo., day, year) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 6 23 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1948 to 11/15 1948, and that I last saw her alive on 11/15 1948

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Comminuted fracture of Left Neck of Femur

Due to Generalized arteriosclerosis

Other Conditions

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN — M. D.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 14.3

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 10/25/48 at 10 A.M.

(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fell down steps at home

23. Signature Dr Marcus W. Moore M.D.

Address Provident Hospital Date signed 11/17/48

VS 150

668677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668677 Registered No. 164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Carrollton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUSSELL SPAYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary E. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1914

8. AGE: Years	Months	Days	If less than one day
34	3	16	hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation: Soldier In U.S. Army
11. Industry or business

FATHER
12. Name: Frank Spayd
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Sallie Keller
15. Birthplace: Pennsylvania

16 (a) Informant: Mary E. Spayd
(b) Address: 101 S. Carrollton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (yr.)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Ave. Balto. Md.

18 (a) Funeral director: Lilly & Zeiler, Inc.
(b) Address: 403 South Wolfe Street Balto.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 8 P. M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of head involving brain

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-48 at 6:30 P. M.
(b) Where did injury occur? 101 S. Carrollton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Firearms

23. Signature: C. J. Sulbrandt M.D. (Medical Examiner)
Date signed 11/16/48

G68678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G68678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Chatham Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Chatham Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HAMMERSLEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William N. Hammersley
13. Birthplace Md.

MOTHER
14. Maiden Name Esther V. Magers
15. Birthplace Md.

16 (a) Informant Miss Olive Hammersley
(b) Address 3820 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Nov 1948, and that I last saw h[illegible] alive on Nov 14 1948.

Immediate cause of death: Carcinomatosis — Duration

Due to Carcinoma of left breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May - 1943

Major findings of operation: Carcinoma of left breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Reich Eacmbs M.D.
Address 101 W. Read St Date signed 11/17/48

VS 150

G68679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

G68679

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Albert Taft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Matilda M. Taft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	20	hr. min.

9. Birthplace Jersey City N.J.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Theodore P. Taft
13. Birthplace New York

MOTHER
14. Maiden Name Narcissa Ashby
15. Birthplace New York

16 (a) Informant Mrs. Edward Taft
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Long Branch N.J.

18 (a) Funeral director J. F. Cline, Sons
(b) Address Reisterstown, Md.

19 NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948 3:25 P.M. to Nov. 17 1948 3:35 and that I last saw h[illegible] alive on Nov. 17 1948.

Immediate cause of death	Duration
Asphyxia	
Due to Laryngeal obstruction	
Due to Carcinoma	
Other Conditions	

CERTIFICATION APPROVED BY PHYSICIAN

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Horace J. Mathias
CHIEF OR ASST. MEDICAL EXAMINER
of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter M.D.
Address Univ. Hospital
Date signed 11-17-48

VS 150

68680 Ost 6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 92D

Registered No. 68680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Goldsborough
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Jan. 30, 1884
8. AGE: Years: 64 Months: 9 Days: 18 If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Joseph Goldsborough
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Emma Brooks
15. Birthplace: Maryland

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Eastern Ave
18 (a) Funeral director: John A. Moran
(b) Address: 3000 E. Balt. St.
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar
NOV 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948, at 100 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1948, to 11-17 1948, and that I last saw him alive on 11-17 1948.

Immediate cause of death: Myocardial Infarction - acute — Duration:

Due to: Arteriosclerotic Cardiovascular Renal

Due to: Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M.D.
Address: The Johns Hopkins Hosp. Date signed 11/19/48

X

VS 150

668681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 668681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 E. Pratt Street
(c) Hospital or institution:

2-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY (or) Maria STELLA

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-7492

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 7-31-70

8. AGE: Years 78 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Bruno Stout
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa Chumboti
15. Birthplace Italy

16 (a) Informant Anthony Stella
(b) Address 1806 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 Belair Rd

18 (a) Funeral director Diegel Bros.
(b) Address 1800 E. Lombard St

19 (a) NOV 18 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948 at 11:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 11-18-48

VS 51

68682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

24a

Registered No. 68682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 54 Webster street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE A. CHEW

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-09-9453

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife: Myrtle Coker Chew
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.): April 29, 1906

8. AGE: Years	Months	Days	If less than one day
42	6	19	hr. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual Occupation: Unknown
11. Industry or business

FATHER
12. Name: Arthur C. Chew
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Martha E. Allgire
15. Birthplace: Maryland

16 (a) Informant: Mrs. Myrtle Chew
(b) Address: Westminster, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/48 (month) (day) (year)
(c) Cemetery or crematory: Westminster
Location: Westminster, Maryland

18 (a) Funeral director: J. Francis Leese
(b) Address: Westminster Md.

19 (a) Nov 18 1948 (Date received by registrar) (b) Courtney for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Nov 1948 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1948 to 18 Nov 1948 and that I last saw h/ alive on 18 Nov 1948

Immediate cause of death: Septicemia — Duration

Due to: Causes unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. P. Young M.D.
Address: V.A. Hospital Date signed: 18 Nov 48

VS 150

68683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838

Registered No. 68683

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3224 Elliott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Anna Poland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry W. Poland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1875

8. AGE: Years	Months	Days	If less than one day
73	8	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frank Tooby
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine Momberger
15. Birthplace Germany

16 (a) Informant Henry W. Poland
(b) Address 3224 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-48 (month) (day) (year)
(c) Cemetery or crematory Saint Matthias
Location Balto Md

18 (a) Funeral director Ellsworth Chapel
(b) Address 911 Liberty Heights Ave

19 NOV 18 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18 19 48 at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 1 19 48 to NOV. 18 19 48, and that I last saw her alive on NOV. 17 19 48.

Immediate cause of death	Duration
CEREBRAL EMBOLISM	2 days
Due to GENERALIZED ARTERIOSCLEROSIS	10 yrs.
Due to	
Other Conditions PARKINSONISM	6 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kirshstein M. D.
Address 121 S. Highland Ave Date signed 11-18-48

VS 150

668684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4517 Eastern Ave.
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4517 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN R. SNIDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-6780

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Snider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1889

8. AGE: Years	Months	Days	If less than one day
59 61	7	24	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name John H. Snider
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Sally Pinkins
15. Birthplace Carroll Co.

16 (a) Informant Mary Snider
(b) Address 4517 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Baust Church Cem.
Location Carroll Co.

18 (a) Funeral director WENDELL J. DIPPEL
(b) Address 312 S. Highland Ave.

19 (Nov 18 1948 (rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x] accident [ ] suicide [ ] homicide [ ] undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D., per Howard J. Sinclair Medical Examiner. M.D.

Date signed 11/18/48

VS 151

G68685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68685,
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 E. Madison St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Frank W. Ruzicka

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Married

6 (b) Name of husband or wife Roseanna Ruzicka (nee Kinzer) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 1, 1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
42	1	15		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business

FATHER
12. Name Frank Ruzicka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Mary Charvat
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Rosa Kinzer Ruzicka - wife
(b) Address 2623 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-5-5 E. Madison Street

19 (a) 19 Nov 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

OK

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1948 to Nov. 16, 1948 and that I last saw him alive on Nov. 16, 1948.

Immediate cause of death	Duration
Typhoid Fever	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, M.D.
Address St. Joseph's Hospital Date signed 11-16-48

X

688686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

688686 6

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Church Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMIL FRANK CISAR, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Barbara M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1885

8. AGE: Years	Months	Days	If less than one day
63	10	2	hr. min

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Coast Guard
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Barbara M. Cisar
(b) Address 1413 Church St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Schumpert Funeral Home
(b) Address 2616 E. Madison St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1948, 10.57 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhy fracture of skull

Due to

Other Conditions Fracture Skull

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-48 at approx. 7.00 P. M.
(b) Where did injury occur Church St., 24' from Pruden
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury pedestrian struck by auto

23. Signature Earl L. Kay M.D. (Medical Examiner)
Date signed November 16, 1948

VS 151

8687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-2a

Registered No. 668687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Inez Rigney

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-4-09

8. AGE: Years	Months	Days	If less than one day
39	9	13	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Gallatin

13. Birthplace Pa.

MOTHER 14. Maiden Name Clara Sherry

15. Birthplace Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)

(c) Cemetery or crematory Mountain Cemetery

Location Baltimore Md.

18 (a) Funeral director Thomas J. Fox

(b) Address 1219 E. Fort Ave.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-17 1948, and that I last saw her alive on 11-17 1948

Immediate cause of death: subarachnoid and ventricular hemorrhage — Duration: hours.

Due to: Cerebral arteriosclerosis — years.

Due to: hypertension — years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid & ventricular hemorrh.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Rizzo, M. D.

Address Johns Hopkins Hosp. Date signed 11-18-48

VS 150

688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 688688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Shamrock Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Mary C. Elburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife John W. Elburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 5, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles W. Leimbach
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Unknown
15. Birthplace Germany

16 (a) Informant Mary A. Rosner
(b) Address 4221 Shamrock Avenue

17 (a) burial (b) Date thereof 11/20/48
(Burial, cremation, or remo) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 19 1948 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1940 to Nov. 16 1948 and that I last saw h[illegible] alive on Nov 16 1948.

Immediate cause of death	Duration
Bronchopneumonia	11 days
Due to	
Due to	
Other Conditions Generalized arteriosclerosis - Senility (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang, M.D.
M. D.
Address 2117 Belair Rd Date signed 11-18-48

V3 150

8689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

668689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edmondson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JEANETTE A. KINNAIRD

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Femele

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Raphael A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 14 1855

8. AGE: Years 92 | Months 11 | Days 3 | if less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: (unknown) Mibler

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden Name: Unknown

MOTHER 15. Birthplace: Germany

16 (a) Informant: Alexander Kinnaird

(b) Address: 8 West 26th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore

Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc

(b) Address: 1217 St. Paul St.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1948 19 , at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 19 44 to Nov 17 19 48 and that I last saw her alive on Nov 17 19 48

Immediate cause of death: Chronic Myocarditis - Cardiac Asthma

Duration: 4 yrs

Due to

Due to

Other Conditions: Arteriosclerosis Cardiac Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature: E. A. Richardson

Address 112 W. 25th St. Date signed Nov 18 1948

VS 150

9.3 D

8690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G68690

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Street
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7224 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hortense W. Gutman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Mr. Leo J. Gutman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1899

8. AGE: Years	Months	Days	If less than one day
49	7	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Whitehill
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura Greif
15 Birthplace Baltimore Md.

16 (a) Informant Mr. Leo J. Gutman
(b) Address 7224 Pk. Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levering & Son
(b) Address 1902 Eutaw Place

19 (a) NOV 19 1948 (b) Huntington Williams M.D.
[To be filled in by registrar]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 1 55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Nov. 19 1948, and that I last saw her alive on Nov. 18 1948

Immediate cause of death	Duration
Multiple metastasis	?
Due to Carcinoma of the Lung	6 mnth.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury H. C. GRAYBEAL

23. Signature H. C. Graybeal M.D.
Address Union Memorial Hospital Date signed 11/19/48

VS 130

591 BC-48-24992 ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 15 E

Registered No. 668691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town 544 Winston Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH NMc GEE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-13-48

8. AGE: Years	Months	Days	If less than one day
0	0	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name James Mc Gee
13. Birthplace Balto Md

MOTHER
14. Maiden Name Betty Mc Ginty
15. Birthplace Balto Md.

16 (a) Informant Father - JAMES McGEE
(b) Address Same 544 Winston St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 19-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location OLd FREDERICK Rd

18 (a) Funeral director CHAS F. EVANS & SON
(b) Address 118 W Mt Royal Ave

19 NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 19 , at 1-55 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13- 1948. to 11-18- 1948.
and that I last saw him alive on 11-18- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease, agenetic group	4 hrs (4 days)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 11-18-48

VS 150

68692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. 68692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Virginia Ave.
(c) Hospital or institution: Mordent Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Ennis Brauch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1921

8. AGE: Years 27 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laundry Worker

11. Industry or business

MOTHER / FATHER
12. Name Samuel P. Green
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Alice Ennis
15. Birthplace Calvert Co. Md.

16 (a) Informant Rev. Samuel P. Green
(b) Address 1209 Riggs Ave.

17 (a) Burial (b) Date thereof 11/23/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Jas. Enright & Sons
(b) Address 6431 Harford Rd.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948 to 11-17 1948 and that I last saw her alive on 11-17 1948

Immediate cause of death: Generalized Peritonitis — Duration

Due to 1. Subphrenic Abscess

Due to 2. Fecal Fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-21-48; 11-8-48

Major findings of operation: Abscess - Fecal Fistula

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Enright
Address 1343 Riggs Ave Date signed M D 11/19/48

VS 150

68693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68693

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mr. James A. Smith
(b) Address 930 Madison Ave.

17 (a) Burial (b) Date thereof 11/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 19 1948 (b) Curtis for Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 12:40 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11, 1948 to Nov 17, 1948.
and that I last saw her alive on Nov. 16, 1948.

Immediate cause of death
Chronic Myocarditis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
14 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 450 W. Biddle Date signed 11/18/48

VS 150

68694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 68694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Bloom Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Bloom Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME SAMUEL J. CARROLL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1869

8. AGE: Years 79 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Insurance solicitor

11. Industry or business

FATHER
12. Name William Carroll
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Georginna Thomas
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs. Rosa Driver
(b) Address 2024 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 19 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948 to Nov. 17 1948, and that I last saw him alive on Nov. 17 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 24 hours

Due to: Essential Hypertension — ?

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 844 N. Carey St Date signed 11/18/48

VS 150

68695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/9/1863

8. AGE: Years	Months	Days	If less than one day
85	5	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Green
15. Birthplace Md

16 (a) Informant Mary Moulton
(b) Address 913 Woodendall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brown Son
(b) Address 108 W Montgomery St

NOV 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28, 1948 to Nov. 6, 1948 and that I last saw her alive on Nov. 15, 1948.

Immediate cause of death: Ch. Val. H. D. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor
Address 522 Harlem Ave Date signed 11/18/48

VS 150

0686596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

0686596
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD McNAIR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	UNKNOWN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace U N (Town, county, and state)

10. Usual Occupation K

11. Industry or business N O

FATHER
12. Name W
13. Birthplace N

MOTHER
14. Maiden Name UN
15. Birthplace KNOWN

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11.19.48 (month) (day) (year)
(c) Cemetery or crematory Payne Cem. Washington D
Location [illegible] NOV 4 1948

18 (a) Funeral director Commissioner of Health
(b) Address Stewart's Funeral Home, Washington

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1948, at 7.50p M

21. I certify that I took charge of the remains described above, held an Inquiry & Insbec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) If injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed November 9, 1948

VS 151

68697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G68697 Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 MALLOW HILL (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert S. Powell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife EDITH E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JULY 24, 1897

8. AGE: Years	Months	Days	If less than one day hr	min.
51	3	23		

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER 12. Name JOSEPH A POWELL
13. Birthplace MARYLAND

MOTHER 14. Maiden Name EMMA HANGARTER
15. Birthplace GERMANY

16 (a) Informant MRS GILBERT S POWELL
(b) Address 216 MALLOW HILL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 22 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) NOV 19 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 17 1948 at 1350 PM

21. I certify that death occurred on the date above stated, that I attended deceased from NOV 1 1948 to NOV 17 1948 and that I last saw him alive on NOV 17 1948

Immediate cause of death: Circulatory Shock — Duration
Due to Gastric Bleeding
Due to
Other Conditions Peripheral Vascular Disease
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E Eisenbach M D
Address Privately Dr Date signed 11-19-48

VS 150

118

68698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

68698 Registered No.

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1104 - N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Floyd Williams

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-92

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	7	22		

9. Birthplace St. Mary Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Chas Dolley
13. Birthplace Md

MOTHER
14. Maiden Name Maggie Jackson
15. Birthplace Md.

16 (a) Informant Lloyd Williams
(b) Address 1106 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Mc Francis E Kenney
(b) Address 578 W. Biddle St

19 (a) NOV 19 1948 (b) Carrington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 1948 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1948 to 11-18- 1948 and that I last saw her alive on 11-18- 1948

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Floyd Woodley M.D.
Address 861 Hanover Date signed 11-18-48

VS (5)

8699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 68699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Pultney Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME FRANCIS ROSENBERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW #2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husbend or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-11-10

8. AGE: Years	Months	Days	If less than one day
38	2	6	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business

FATHER
12. Name Joseph Rosemberger
13. Birthplace Maryland

MOTHER
14. Maiden Name W. C. Seitz
15. Birthplace Maryland

16 (a) Informant Family
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location 5501 Frederick Avenue

18 (a) Funeral director JAMES L. McCULLY
(b) Address 130 East Fort Avenue

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 7:3[illegible] PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of head of Pancreas

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schmidt M.D.
Medical Examiner.
Date signed 11/18/48

8760.0a

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1600

668700
Registered No.

I.C. 48-25991

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 N Central ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) N. B. 11/17/48
8. AGE: Years | Months | Days | If less than one day 2 hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Steven Johnson
13. Birthplace ?
MOTHER 14. Maiden Name Mary ?
15. Birthplace ?
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Joseph S. [illegible]
(b) Address 1304 N. Central Ave
19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-1948 at 3.40 M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19
Immediate cause of death Prematurity
Hyaline membrane
Due to Dead on Arrival
Due to
Other Conditions Subarachnoid Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
Duration ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

CERTIFICATION APPROVED BY
Wm. H. Kammer, M.D.
Per [illegible] M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 11-19-48

VS 150

To be approved by Med Exr

68701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

68701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Atlanta (If outside city or town limits, write RURAL and give town)
(d) Street No. 3651 Tuxedo Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: DAUGHTY R. MANLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: Christine McEachern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1903

8. AGE: Years 45 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace: Atlanta (Town, county, and state)

10. Usual Occupation: Merchant Marine

11. Industry or business

FATHER
12. Name: W.D.Manley
13. Birthplace: Georgia

MOTHER
14. Maiden Name: Valeria Rankin
15. Birthplace: Georgia

16 (a) Informant: Mrs. Valeria R. Manley
(b) Address: 3651 Tuxedo Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Atlanta, Ga.

18 (a) Funeral director: Wm. J. Ticknor & Sons
(b) Address: Baltimore, Md.

19 NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema
Myocardial degeneration
Fatty Degeneration of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 11-18-48

VS 191

G68702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G68702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Guilford Ave. & 34th St.
(c) Hospital or institution:
Temple Court Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Court Apts. Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kitty Livingston DeFarges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Herbert C. De Farges Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1883

8. AGE: Years	Months	Days	If less than one day
65	7	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin C. Livingston
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma——
15. Birthplace Unknown

16 (a) Informant Mr. John L. De Farges (Son)
(b) Address Temple Court Apts. Balto.

17 (a) Nov. 19, 1948 (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director William J. Tickner & Sons,
(b) Address 34th & Pennsylvania Aves.

19 (a) NOV 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 to 11/17 1948.
and that I last saw her alive on 11/16 1948.

Immediate cause of death: Carcinoma of the ovary & peritoneal metastases. — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L. Livingston Jr. M.D.
Address 1114 St. Paul St. Date signed 11/19/48

VS 153

G68703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G68703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Falls Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 FALLS RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH MARKOWITZ

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6. (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife JENNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1895

8. AGE: Years 53 | Months | Days | If less than one day hr min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name JONAS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DENA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Philadelphia Rd + HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl. Baltimore, Md.

19 (a) (Date received by Registrar) (b) Registrar

NOV 19 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 19 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 19 1948, and that I last saw him alive on 11/19 1948.

	Duration
Immediate cause of death Acute Cardiac Failure	
Due to Chronic Hypertrophied Prostate	
Due to Ruptured Varicose Veins PERIPHERAL	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 11/19/48 M.D.

X

68704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 68704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Shack in rear of 1620 Benhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shack in rear of 1620 Benhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS CEBULSKI OR CYBULSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ? Cebulski
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant John Supy
(b) Address 1620 Benhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 19 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russi
Location Elkridge, Maryland

18 (a) Funeral director John A. Grebliauckas Jr.
(b) Address 423 S. Paca Street

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1948, at 3:50 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

over

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 11/18/48

VS 151

668705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

668705 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4332 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Charles Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-2532

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1925

8. AGE: Years	Months	Days	If less than one day
23	1	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O

FATHER 12. Name George J. Ruppert

13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Margaret Ruppert

15. Birthplace Maryland

16 (a) Informant Mrs. Anna M. Ruppert

(b) Address 4332 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director John A. Moran

(b) Address 3006 E. Baltimore St

19 (a) NOV 19 1948 (Date received by registrar) (b) Huntington Nolliamus, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1948 at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/ 1948 to 11/19/ 1948 and that I last saw him alive on 11/19/ 1948.

Immediate cause of death	Congestive Failure	Duration
Due to	Aortic stenosis and mitral stenosis	
Due to	Rheumatic Heart Disease	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Rheumatic Heart Disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clay E. Russum Jr. M.D.
Address St. Joseph's Hospital Date signed 11/19/48

VS 192

58706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114D

Registered No. 58706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6819 Dunkill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick L. Murphy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife KATHLEEN E MURPHY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/8/1897

8. AGE: Years 51 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Machanist
11. Industry or business Bethlehem Steel

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Stenson
15. Birthplace Ireland

16 (a) Informant HARRY McCORMICK
(b) Address 6819 DUNKILL RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location 4300 OLD FREDERICK RD

18 (a) Funeral director Roland L Fisher
(b) Address 2112 DUNDALK AVE.

NOV 19 1948
(Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/17/1948 and that I last saw him alive on 11/17 1948.

Immediate cause of death CARDIO - RESPIRATORY FAILURE — Duration

Due to LUNG ABSCESS

2 GENERALIZED SEPTICEMIA

Due to ENCEPHALITIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Shaw M. D.
Address 1510 Gwynn Oak Ave. Date signed 11/19/48

VS 159

668707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. 668707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Clifton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
if yes, name country

3 (a) FULL NAME Thomas F. Sheehan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Georgia Applegarth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/29/1883

8. AGE: Years	Months	Days	If less than one day
65	9	19	hr. min.

9. Birthplace Md.
10. Usual Occupation Sr. Auditor - Comp Office
11. Industry or business State of Md

FATHER
12. Name Cornelius Sheehan (dec)
13. Birthplace England

MOTHER
14. Maiden Name Rose Corrigan (dec)
15. Birthplace Ireland

16 (a) Informant Mrs Georgia A. Sheehan
(b) Address 3602 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. F. Means and Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1948, at 3.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1948, to 11/18 1948, and that I last saw him alive on 11/18 1948.

Immediate cause of death: Cirrhosis of the Liver
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: ?

Date of operation None
Major findings of operation
of autopsy: Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Knickes M.D.
Address St. Agnes Hosp. Date signed 11/19/48

VS 150

X

FRANK CROOKS

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68708

G68708

462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution: Balt. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Crooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Crooks

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Sept. 3, 1869

8. AGE: Years 79 Months 2 Days 17 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Runner

11. Industry or business

FATHER
12. Name John Crooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Charolette Grimes
15. Birthplac Maryland

16 (a) Informant Mrs. Mary V. Crooks
(b) Address Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Balto. Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-48 19 at 9 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1948 to 11-17 1948. and that I last saw him alive on 11-17 1948.

Immediate cause of death: Respiratory collapse

Due to: Metastatic Ca of Stomach

Due to:

Other Conditions: Arteriosclerosis & Benign Prostatic Hypertrophy
(Include pregnancy within 3 months of death)

Date of operation 11-12-48

Major findings of operation: Inoperable Ca of stomach with intestinal obst.

Autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Pratt Jr. M.D.
Address University Hospital Date signed 11-17-48

VS 150

68709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 68709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN CHESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Anna Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 1, 1872

8. AGE: Years	Months	Days	If less than one day
76	3	17	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Chester
13. Birthplace

MOTHER
14. Maiden Name Agnes Moreilas
15. Birthplace

16 (a) Informant Mrs. Anna Chester
(b) Address 3404 Walbrook Ave.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Maus.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948, at 9:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 14 1948 to Nov 18, 1948, and that I last saw h[illegible] alive on 11/12 1948

Immediate cause of death Carcinoma of Prostate — Duration 4 years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich, Jr. M. D.
Address 1227 Wash Blvd Date signed 11/19/48

VS 150

068710

BALTIMORE CITY HEALTH DEPARTMENT X V Registered No. 068710

CERTIFICATE OF DEATH 51C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town 29 Wright Aileron St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES TURNBULL

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Virginia E. Turnbull
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 7, 1916
8. AGE: Years 32 | Months 9 | Days 9 | If less than one day: hr. min.
9. Birthplace Belfast, Ireland (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Glenn Martin

FATHER
12. Name Andrew Turnbull
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Mawhinney
15. Birthplace Ireland

16 (a) Informant Mrs. Virginia E. Turnbull
(b) Address 1216 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 4:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 5-18 1948 to 11/16 1948 and that I last saw him alive on 11/16 1948

Immediate cause of death: Carcinoma (Embryonal) left testicle — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 1947
Major findings of operation: Embryonal left testicle
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John P. Ulrich, Jr.
Address (22) Wash. Blvd. Date signed 11/19/48 M.D.

VS 130

668711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

668711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 71 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. more (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Lake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Dittmar

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-3975

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	4	10		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Wood worker
11. Industry or business John Dittmar & Sons Inc.

FATHER 12. Name John Dittmar
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Hess
15. Birthplace Germany

16 (a) Informant ~~Mrs Eleanor~~ Mrs O.B. Colonta Jr.
(b) Address Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1948, at 1.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 19 48 to Nov 18 1948, and that I last saw h[illegible] alive on Nov 18 19 48

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Frank Supplee, Jr.
Address Union Memorial Hosp. Date signed 11/19/48

VS. 150

66871.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66871.2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2788½ The Alameda
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2788½ The Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE L. JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-07-8521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Murrill E. Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 11, 1891

8. AGE: Years	Months	Days	If less than one day
57	0	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Edward Hartman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Miller
15. Birthplace Gettysburg, Pa.

16 (a) Informant Mrs. Katherine Stromyer
(b) Address 2788½ The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948, at 10:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1st 1948 to Nov. 16 1948 and that I last saw her alive on Nov 16 1948

Immediate cause of death: Acute Cardiac Failure
Due to Pulmonary Edema
Due to Chronic Myocarditis & Hypertension

Duration: 1 day, unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Ashman M.D.
Address 1420 W. Saratoga Date signed 11/18/48

VS 150

G68713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G68713

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Homestead
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebecca Fonshell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harry S Fonshell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-3-1881

8. AGE: Years 71 | Months 0 | Days 17 | If less than one day hr. min.

9. Birthplace Frederick, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William B. Shilling
13. Birthplace England

MOTHER
14. Maiden Name Ellie R. Castle
15. Birthplace Frederick, Md

16 (a) Informant Mrs. Wm Fonshell
(b) Address 1109 Homestead

17 (a) Burial (b) Date thereof 11/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1948 (b) Baltimore, Md.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948, at 5 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1948 to 11-17 1948, and that I last saw h e alive on 11-16 1948

Immediate cause of death: Obstruction of common bile duct due to Stone

Due to: Pyonephrosis left Kidney due to Stone in Kidney

Other Conditions: ASHD

(Include pregnancy within 3 months of death)

Duration: 2 wks

Date of operation: Jan

Major findings of operation:

of autopsy: Yes above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A Bond M D

Address Church Home Date signed 11-22-48

0

X

668714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668714

157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Gastonia (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 776 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Karen Patton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-48

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard J. Patton

13. Birthplace N C

MOTHER 14. Maiden Name Nell Mc Swain

15. Birthplace N C

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)

(c) Cemetery or crematory Gastonia

Location N. C.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 112-22 Lefferts Pl. Kew Gardens, N.Y.

19 NOV 19 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 2 P.M. JR

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1948 to 11-19 1948 and that I last saw h[illegible] alive on 11-19-1948.

Immediate cause of death Congenital Cardiac Malformation

Duration

Due to

Due to

Other Conditions Bilat. cleft lip and cleft palate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac malformation

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John J. Ryan M. D.

Address Johns Hopkins Hosp Date signed 11/19/48

VS 150

68715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

Registered No. 68715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Forrest St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARLENE R. WALKER

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife M onroe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 19, 1916

8. AGE: Years 32 | Months 3 | Days 29 | If less than one day: hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Irving Bennett
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Dewey
15 Birthplace N.Y.

16 (a) Informant Mrs Mary Snyder
(b) Address 1126 Forrest St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Willian Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 20 1948 (Date received by registrar) **(b)** Huntingdon Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 19 . at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1948 to 18 Nov 1948, and that I last saw h alive on 17 Nov 1948.

Immediate cause of death Hypostatic pneumonia — Duration 2 Days

Due to Brain tumor, recurrent. — 1 yr

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1947

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dwight B Capen, Jr M.D.
Address 2893 St. Paul Date signed 11-19-48

68716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 68716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Orlando Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Orlando Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH COOK

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel B.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 23, 1893

8. AGE: Years 55 | Months 7 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Packham
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Sweden
15. Birthplace Md

16 (a) Informant Evelyn Kalbshopf
(b) Address Ridgely Ave., Fullerton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Towson Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) Date received NOV 20 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 19 ____ at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 48 to Nov. 18, 19 48 and that I last saw her alive on Nov. 18 19 48.

Immediate cause of death: Hypertensive Cardio-Vascular Disease. — Duration 10 yrs.

Due to Cerebral Hemorrhage

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.
Address 7101 Harford Rd Date signed 11/19/48

VS 150

92

G6871.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G6871.7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANORA - SANDLASS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard E. Sandlass

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Jan. 22. 1874

8. AGE: Years 74 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Louis Kleinhenn
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Schmidt
15. Birthplace Germany

16 (a) Informant Richard E. Sandlass
(b) Address 4409 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location Catto-City

18 (a) Funeral director Mr. Mrs. John W. Tenfel & Son
(b) Address 5311 Edmondson Ave

19 NOV 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Nov 19 1948, and that I last saw her alive on Nov 18 1949.

	Duration
Immediate cause of death: Coronary occlusion	4 hr
Due to: Hypertension Cardio Vasc. Renal	1 yr
Due to: Diabetes	30 yrs
Other Conditions: Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	10 yrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Thos J Abbott M.D.

Address 4509 Liberty Heights Date signed Nov 20 48

V S 150

668718 — Bickle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ 668718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga | 29
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1609 Kingsway Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie Bickle (Wilhelmina — Known as Minnie)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
F	W	

6 (b) Name of husband or wife John H. Bickle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-14-1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	9	8	5	

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Dreemer
13. Birthplace Germany

MOTHER
14. Maiden Name Theodora Pfleich
15. Birthplace Germany

16 (a) Informant James Bramwell
(b) Address 1609 Kingsway Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto Md

18 (a) Funeral director Uhlich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 20 (Date rec'd by registrar) Washington Wilhelmina Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1948 at 9 5/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1948 to 11-19 1948, and that I last saw her alive on 11-19 1948.

Immediate cause of death	Duration
Generalized Hemmorrhage	
Due to Chronic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Leukemic infiltration
of autopsy Gen. Hemmorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Powell Jr. M D
Address Mercy Hosp Date signed 11/20/48

Harry Powell Jr

68719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town ~~Balto~~ Snow Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1111 Mt. Auburn St.~~
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife Frank T. Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1860

8. AGE: Years 87 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Snow Hill, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William T. Bryden
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Riley
15. Birthplace Maryland

16 (a) Informant Mrs. William C. Jones Sr.
(b) Address Snow Hill, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)
(c) Cemetery or crematory Baley Mem
Location Snow Hill Md

18 (a) Funeral director Clay E. Dennis
(b) Address Snow Hill Md

19 (a) NOV 20 1948 (Filed rec'd by registrar) (b) Huntington Wallace M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948 to 11/19 1948 and that I last saw h alive on 11/19 1948.

Immediate cause of death: Pneumonia

Due to Cerebral vascular accident

Due to Contributed

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Blazer M. D.
Address Date signed 11/19/48

VS 150

668720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N. WASHINGTON ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N WASHINGTON ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME HOWARD D. DEAL

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Grace W. Deal
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	0	5	hr. ____ min. ____

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Deal
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza J. Duncan
15. Birthplace Balto. Md.

16 (a) Informant Miss Grace Deal
(b) Address 528 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Episcopal Cem
Location Balto. Md.

18 (a) Funeral director Philip Henrijsons
(b) Address 2024 Orleans St.

19 (a) NOV 20 1948 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 2.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Nov 19 1948, and that I last saw him alive on Nov. 18 1948.

Immediate cause of death: Cerebral Vascular hemorrhage — Duration: 6 days
Due to Hypertension — Duration: ?
Due to Arteriosclerosis — Duration: ?
Other Conditions Blind in left eye
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ____ M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Melvin H. Borden, M. D.
Address 2030 W. Fayette Date signed 11/19/48

Print age in space if exact age is especially important. Physicians: please write the causes of death clearly and legibly.

68721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Mt.Holly St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Mt.Holly St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie V.Griffith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry M.Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 25 1869

8. AGE: Years	Months	Days	If less than one day
79	1	25	24 hr. min.

9. Birthplace Cambridge Ohio
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name David Britton
13. Birthplace Virginia

MOTHER
14. Maiden Name Prudence DeSellems
15. Birthplace Cambridge Ohio

16 (a) Informant Anna B.Snyder
(b) Address 2108 Mt.Holly St.

17 (a) Burial (b) Date thereof Nov 24 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Uniontown
Location Kanags

18 (a) Funeral director Harry A Linnacre
(b) Address 4204 Ridgewood Ave

19 (a) NOV 20 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 19 48, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 48, to Nov 19 19 48.
and that I last saw h alive on Nov 1 19 48.

Immediate cause of death	Duration
Cerebral Embolism	4 days
Due to Coronary Sclerosis	1 yr
Due to Arteriosclerosis	5 yrs
Other Conditions Diabetes Mellitus	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Date signed

VS 150

8722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

✓ 668722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Dawson Reeder M.D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of ~~husband~~ or wife Anne Carey Reeder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 16, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	2	hr. min.

9. Birthplace Dorchester Co. Maryland (Town, county, and state)
10. Usual Occupation M.D.
11. Industry or business

FATHER
12. Name Charles M. Reeder
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name K. M. Dawson
15. Birthplace Dorchester Co. Maryland

16 (a) Informant Home for Incurables records - C.E.
(b) Address 700 W. 40th St. Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. McCall & Son, Inc.
(b) Address 1900 Eutaw Place

19 NOV 20 1948 (b) Huntington Williams M.D. (Registrar)
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1948, at 6:50 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 10 1946, to Nov. 18 1948, and that I last saw h~~im~~ alive on Nov. 17 1948

Immediate cause of death: Coronary Thrombosis — Duration 4½ days
Due to: Hypertensive - Arteriosclerotic Cardio Vascular Disease — Duration Over 5 years
Due to:
Other Conditions: Dental Caries and Oral Sepsis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St Date signed 11-18-48

VS (5)

68723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. 68723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Pimlico Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4311 Pimlico Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C. Dishon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1872

8. AGE: Years	Months	Days	If less than one day
76	8	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Food Dispensary.

FATHER
12. Name David Dishon
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Reed
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Margaret V. Dishon
(b) Address 4311 Pimlico Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Lorraine Cemetery
(b) Address 5385 Park Heights Ave.

19 (a) NOV 20 1948 (Date rec'd by registrar) Emerson Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1948, to Nov 18 1948, and that I last saw h— alive on Nov 18 1948

Immediate cause of death
Arteriosclerosis
Cerebral thrombosis

Duration
8 yrs.
2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature O. H. Cauce M.D.
Address 2818 Pr Ave Date signed 11/20/48

VS 150

66724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 66724

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 704 Mc Henry St.

(c) Hospital or institution: -

(d) Length of stay in hospital or inst. (yrs., mos., or days) -

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 704 Mc Henry St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Ernest Musgrove

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-5566

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1889

8. AGE: Years 59 | Months 1 | Days 16 | If less than one day: hr. 17 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Musgrove

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Emma Shaffer

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Katherine Musgrove

(b) Address 704 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Rd. Baltimore

18 (a) Funeral director Byrle W. Fackenthal

(b) Address 703 Mc Henry St.

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1948 12:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 17 1948.

and that I last saw h alive on Nov 16 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Chronic Cardiovascular disease

Due to: uric hypertension — 6 yrs

Other Conditions (include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Emmett H. Dalton M.D.

Address 732 Poplar Ter Date signed 11/17/48

VS 150

Physicians: please write the causes of death clearly and legibly. Especially important.

MCo. 1-11 1948

HEALTH DEPARTMENT—CITY OF BALTIMORE

68725 (68725)

CERTIFICATE OF DEATH 61

1. PLACE OF DEATH 4200 N. Howard St.

CITY OF BALTIMORE: (No.) Virginia Lee Nursing Home St., (Ward) 8

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Julia Charlotte Cochel (w)

(a) Residence: No. 3345 W. Garrison Ave. St., ... Ward. ...
(Usual place of abode) (If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chester Cochel

6. DATE OF BIRTH (month, day, year) Sept 26, 1878

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	1	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) New York New York

FATHER

13. NAME John Scarabilicci

14. BIRTHPLACE (city or town) (State or country) Trieste Italy

MOTHER

15. MAIDEN NAME Emma Voelmer

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mr. Charles Cochel
(Address) 4030 Belle ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Druid Ridge Date 11-22 1948

19. UNDERTAKER Wm J. Tickner & Sons
(Address) Balto, Md.

20. FILED NOV 20 1948 Twetington Williams, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 18 1948

22. I HEREBY CERTIFY, That I attended deceased from Sept 9 1948 to Nov 18 1948
I last saw her alive on Nov 18 1948 death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	11-7-48
Other contributory causes of importance	
Cystitis & Cystitis	7
Decubitus Ulcers	9

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Samuel Hueber M. D.

(Address) 5611 Pimlico Rd

068726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B.

Registered No. G68726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PERCY LESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Blanche Reed Lester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1876

8. AGE: Years	Months	Days	If less than one day
72	4	10	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Credit Dept. - Clerk
11. Industry or business Brager & Eisenberg

FATHER
12. Name Wm. J. Lester
13. Birthplace Engl and

MOTHER
14. Maiden Name Sarah Ann Brooks
15. Birthplace England

16 (a) Informant Mrs. Blanche R. Lester
(b) Address 2212 N. Charles St.

17 (a) Burial (b) Date thereof 11/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 20 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948. to Nov 18 1948.
and that I last saw h IM alive on Nov. 18 1948

Immediate cause of death Carcinoma of Stomach — Duration 5 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Dawes M. D.
Address 800 W 33rd St Date signed 11-19-48

668727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 668727

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE KAMAITIS

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No. 104-07-2765

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Eva ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887

8. AGE: Years	Months	Days	If less than one day
61	10	11	hr. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual Occupation: Carp enter
11. Industry or business

FATHER: 12. Name: George Kamaitis
13. Birthplace: Lithuania

MOTHER: 14. Maiden Name: Eva ?
15. Birthplace: Lithuania

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23-48 (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Rochester N. Y.

18 (a) Funeral director Joseph Kaufman
(b) Address 602 York Road

19 (a) NOV 20 1948 (Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 19 48 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 19 48 to Nov. 18 19 48, and that I last saw h in alive on Nov. 18 19 48.

Immediate cause of death: Chronic lymphatic leukemia — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address U.S. Marine Hosp. Baltimore 11, Md. Date signed 11-18-48

VS 350

668728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 668728

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Dulaney Ave

(c) Hospital or institution: West Baltimore Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2117 E. Monument Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Barracca Jennie BARRACCA

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0441

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: BENEDETTO V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 27 1908

8. AGE: Years: 39 | Months: 10 | Days: 23 | If less than one day: hr. min.

9. Birthplace Gaeta Italy (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Joseph Vacucci

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Esposito

15. Birthplace Italy

16 (a) Informant B. L. Barracca

(b) Address 2117 E. North Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 22-48 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR Rd. BALTIMORE

18 (a) Funeral director Frank Della Rocca

(b) Address 322 S. High St.

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to Nov 19 1948.

and that I last saw her alive on Nov 19 1948.

Immediate cause of death Pneumonia, RLL & LUL

Due to pneumococcus, sputum

Other Conditions 2) Subacute bacterial endocarditis

3) Rheumatic heart disease with mitral stenosis

(Include pregnancy within 3 months of death)

Duration: 1 week; (2); many years

Date of operation

Major findings of operation:

of autopsy Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Marion L. Dana, M.D.

Address Md Bell Gen Hosp Date signed 11-19-48

VS 150

68723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. 68729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Binder Court.
(c) Hospital or institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Binder Court.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ester Belle Hicks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Eddie Hicks 38yrs.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1915

8. AGE: Years	Months	Days	If less than one day
32	11	19 21	— hr. — min.

9. Birthplace Campbell County, VA.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business —

FATHER
12. Name Abraham Martin
13. Birthplace Campbell County, VA.

MOTHER
14. Maiden Name Roxie Anna Shepperson
15. Birthplace Campbell County, VA.

16 (a) Informant Rose Anna Hall (sister)
(b) Address 30 53rd St. S.E. Wash. D.C.

17 (a) Burial (b) Date thereof 11-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Location Lynchburg Va.

18 (a) Funeral director A. Holland
(b) Address 918 Lewis Street Lynchburg Va.

19 (a) [illegible] (b) [illegible]
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19, 1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1948 to 11-19 1948.
and that I last saw her alive on 11-17, 1948.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Rheumatic Fever
Avitaminosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. L. Mok, M.D.

Address 303 Bridgeview Pl Date signed 11/19/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68730

68730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Phillips.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Jane Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): November 5, 1868.

8. AGE: Years: 80 | Months: - | Days: 11 | If less than one day: hr. min.

9. Birthplace: Kent County Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: James Phillips
13. Birthplace: Kent County Md.

MOTHER
14. Maiden Name: Annie Ringgold
15. Birthplace: Md

16 (a) Informant: Herbert Phillips.
(b) Address: 1126 Orrell Ave. Atlantic City N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 322 N. Schroeder St

19 (a) NOV 20 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1948 to Nov 16 1948
and that I last saw h[illegible] alive on 11/7/1948

Immediate cause of death: Myocarditis — Duration: Unknown
Due to: arteriosclerosis
Due to: Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Walter J Lorton
Address: 1013 Edmondson Ave Date signed 11/18/48 M. D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

668731 Registered No. 668731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 W. Hill St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gladys E. Jackson. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1917.

8. AGE: Years	Months	Days	If less than one day
31	7	19	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Sneed Ward.
13. Birthplace Md.

MOTHER
14. Maiden Name Maria
15. Birthplace Md.

16 (a) Informant Edna Burrell.
(b) Address 107 W. Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Longwood St.

19 (a) Nov 20 1948 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948. at 7:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 4 1948 Nov. 17 1948 and that I last saw h alive on Nov 17 1948

Immediate cause of death
(a) Acute Bronchopneumonia Duration 2 wks.
Due to
(b) Influenza 3 wks.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Linda P. Jeffrey
Address 908 S. Bway Date signed 11/19/48

VS 199

G68732

G68732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1647 E. Madison St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1647 E Madison St (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Roy Kenny

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1901

8. AGE: Years	Months	Days	If less than one day
47	3	6	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Leroy Kenny

13. Birthplace Buckingham Co Va.

MOTHER 14. Maiden Name Margaret Kenny

15. Birthplace Buckingham Co Va.

16 (a) Informant Leroy Kenny

(b) Address 1510 Division St.

17 (a) Removal (b) Date thereof Nov 20/48 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Buckingham Co Va.

18 (a) Funeral director Mrs. Ethel E. Elliott

(b) Address 429 N. Carrollton

NOV 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1948, at 4.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946, to Nov 18th 1948, and that I last saw h-e alive on Nov 18th 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Osborn M.D.

Address 222 W. Bond St Date signed 11/19/48

VS 8

668733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 668733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Pine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Pine Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James William Hines

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-8865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Annabelle Hines

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 17, 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	6	1		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Hat Blocker

11. Industry or business Brigham - Hopkins

FATHER — 12. Name John Joseph Hines
13. Birthplace Maryland

MOTHER — 14. Maiden Name Catherine Kierney
15. Birthplace Maryland

16 (a) Informant Annabelle L. Hines
(b) Address 2119 Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George J. Schwab
(b) Address 1911 Edmondson Ave.

19 (a) NOV 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948, at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/47 1947 to 11/18 1948, and that I last saw him alive on 11/18 1948.

Immediate cause of death: Carcinoma of Stomach

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Fulton III
Address 1949 N. Calvert St. Date signed 11/18/48 M

VS 150

G68734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S. London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S. London Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina (Minnie) Beverley Blomeier — (Blomeier)

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife William Blomeier
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct. 20, 1862
8. AGE: Years 86 | Months — | Days 30 | If less than one day hr. min.
9. Birthplace Catonsville, Balto. County, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name John Preissinger
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Ruff
15 Birthplace Germany

16 (a) Informant Carl F. T. Blomeier
(b) Address 146 S. London Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville, Md.
18 (a) Funeral director George L. Schwab
(b) Address 201 Frederick Ave Huntington Williams, M.D.
19 (a) (Date received by reg.) NOV 21 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1930 to Nov 19, 1948 and that I last saw h[illegible] alive on Nov 17 1948.

Immediate cause of death Coronary Occlusion — Duration Sudden
Due to Cardio-Vascular Disease & Decompensation — 1 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elias W. Johnson
Address 3652 Frederick Ave Date signed 11-24-48

Cert. of Notification X

VS 150

G68735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68735

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2511 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 W. Lombard St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edwin Gainor

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Charlotte R. Gainor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 16, 1877

8. AGE: Years 70 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Wilmington, Delaware
(Town, county, and state)

10. Usual Occupation City Employee
11. Industry or business [illegible]

FATHER
12. Name Edwin T. Gainor
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Hedderick
15. Birthplace

16 (a) Informant Charlotte R. Gainor
(b) Address 2511 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Geo. T. Schwab
(b) Address 2101 Fredrick Ave.

19 (a) NOV 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948, at 12:02 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 19 48 to Nov 19 19 48. and that I last saw h[illegible] alive on Nov 18 1948.

Immediate cause of death
Coma
Thrombosis
Due to Arteriosclerotic C.V. disease

Duration 3 days

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature [illegible] 2503-W. 63-rd St.
Address 11/19/48 Date signed

VS 150

668736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 668736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4322 Glenmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4322 Glenmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fredericka M. Schuster

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George M.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 28 - 1869

8. AGE: Years: 79 | Months: - | Days: 21 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: At Home
11. Industry or business

FATHER 12. Name: Adam J. Walter
FATHER 13. Birthplace: Balto.

MOTHER 14. Maiden Name: Sophia Hammel
MOTHER 15. Birthplace: Balto.

16 (a) Informant: Loretta. Muhlmeister
(b) Address: 4322 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 22 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Brooklyn

18 (a) Funeral director: Riggel Bros.
(b) Address: 711 O Belair Rd.

19 (a) Nov 21 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 1948 at 10:39 A.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from Sept. 9 1948 to Nov. 19 1948. and that I last saw h-r alive on Nov. 18 1948.

Immediate cause of death: Metastatic Carcinoma of Lungs — Duration: 2 mos.
Due to: Papillo Fibroma of Kidney
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: May 13 - 1946
Major findings of operation: Papillo fibroma of kidney - Metastatic epithelioma glands.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature: Wm D Johnston, M.D.
Address: 701 N. Linwood Ave.
Date signed: 9/9/49

VS 150

668737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

668737 ?

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6300 Pinehurst Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Carpenter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances Ciarrocca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/08

8. AGE: Years 40 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Herbert L. Carpenter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth B. Clarke
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances G. Carpenter
(b) Address 6300 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) 1948 (Date received by registrar) Thompson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1948, at 9:55 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/10 1948 to 11/18 1948, and that I last saw h[illegible] alive on 11/18 1948.

Immediate cause of death [illegible] Duration

Due to Accumulation of serum in pericardial sac

Due to Coronary thrombosis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Blazer M.D.
Address [illegible] Date signed 11/18/48

VS 100

118

668738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2250 SIDNEY AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2250 SIDNEY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYRTLE ELSIE RIDDLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife GILBERT O. RIDDLE

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) JULY 21, 1888

8. AGE: Years 60 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace EASTON, Md.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name SOLOMON COVEY
13. Birthplace EASTON, Md.

MOTHER
14. Maiden Name MARY CATHARINE (?)
15. Birthplace EASTON, Md

16 (a) Informant GILBERT O. RIDDLE
(b) Address 2250 SIDNEY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 22 NOV. 1948 (month) (day) (year)
(c) Cemetery or crematory M.E. CHURCH CEM
Location EASTON, Md.

18 (a) Funeral director Walter Bruce Bradley
(b) Address 1922 W. North Avenue
(c) Date 1948 Twentington Williams, M.D. Registrar
(Date rec'd by registrar)

NOV 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948 at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1948 to Nov. 20 1948 and that I last saw her alive on Nov. 20 1948

Immediate cause of death
Myocarditis
Due to Hypertension
Acute Bronchitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3 yrs
4 hrs
1 wk.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry E. Yates
Address 517 Scott St. Date signed 11/30/48

VS 150

G68739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G68739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LENA GERSHOWITZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abraham | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1875

8. AGE: Years 72 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Not Known
13. Birthplace Germany
MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs Helen Boak
(b) Address 308 E Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 NOV 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 19 1948 and that I last saw her alive on Nov 19 1948

Immediate cause of death RESPIRATORY FAILURE + TOXEMIA — Duration

Due to CARCINOMA OF GALLBLADDER & DUCTS & TOXEMIA.

Due to

Other Conditions OBSTRUCTIVE JAUNDICE DUE TO CA.
(Include pregnancy within 3 months of death)

Date of operation Nov. 11, 1948

Major findings of operation: INOPERABLE CARCINOMA OF BILIARY SYSTEM

of autopsy: Ca of GALLBLADDER + DUCTS

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Merle S. Schers, M.D. M. D.

Address Sinai HOSPITAL Date signed 11-19-48

VS 153

G68740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 W Franklin
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W Franklin
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZEBETH B. MENDELIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph F. Mendelis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Feb 14 1873~~ May 29 1873
If less than one day, hr. min.

8. AGE: Years 73 (75) | Months 5 | Days 21

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Jerald Pocius
13. Birthplace Lithuania

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Bert Mendelis
(b) Address 114 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W Faehnrich
(b) Address 703 McHenry St.

19 (a) Nov 22 1948 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Nov 19 1948, and that I last saw her alive on Nov 19 1948.

Immediate cause of death	Duration
Pulmonary Embolism	7 hrs
Due to Auricular Fibrillation	24 hrs
Due to Coronary Heart Disease	10 years

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Mendelis M. D.
Address 651 N Fremont Ave Date signed 11-19-48

VS 150

Physicians: please write the causes of death clearly and legibly.

G68741
JL - 119714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G68741

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Mason (Wilbert Mason)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 26, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	16	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Rest
Location Loudon Park Hill Rd

18 (a) Funeral director Fahrkamp
(b) Address 3138 Eighth St.

19 (a) 4060 Huntington Williams Ave
(Signature or initials by registrar)

NOV 23

VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH Nov. 12 1948, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1948, to Nov. 12 1948, and that I last saw him alive on Nov. 12 1948.

Immediate cause of death: Pulmonary Edema — Duration: hour

Due to: Hypertensive Cardio, Vascular disease Uremia — Duration: ? Yrs.

Due to

Other Conditions: Cirrhosis of Pancreatitis

(Include pregnancy within 3 months of death)

Date of operation 6/10/48 1/23/48

Major findings of operation: Exp

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11/23/48

929

G68742 ✓ G68742

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

G68742

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2557 McCulloh st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Henry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Josiah Henry
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr) 1-15-79

8. AGE: Years	Months	Days	If less than one day
69	10	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lloyd Wheatley
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Keene
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Cambridge Md.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address: 1211 N. Arlington Ave

19 (a) 11-21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 7.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1948 to 11-19 1948, and that I last saw h~~e~~ alive on 11-19 1948.

Immediate cause of death	Duration
Cerebrovascular accident	
Due to cerebral embolism EMBOLUS	
Due to Auricular fibrillation AURICULAR	
Other Conditions,	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 11-20-48

VS 150

668743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 668743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521- Camel Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521- Camel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Belle Ridgley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ? 1866

8. AGE: Years 82 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Billie Ridgley

13. Birthplace Va.

MOTHER 14. Maiden Name Isabelle ?

15. Birthplace Va.

16 (a) Informant Joe Ridgley

(b) Address 800- Booth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 1948

(c) Cemetery or crematory [redacted] Cemy

Location Mt. Calvary

18 (a) Funeral director A. Polsteach

(b) Address 918- Reid St.

19 (a) (Date received by registrar) Registrar Washington Williamson, M.D.

(b) Registered

NOV 21 1948

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 / 18 / 1948 at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/1948 to 11/18/1948 and that I last saw her alive on 11/16/1948

Immediate cause of death: Chronic Myocarditis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address 450 W. Biddle St. Date signed 11/20/48

X

G68744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Ellwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANISLAUS JEDRZEJCZAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1870

8. AGE: Years	Months	Days	If less than one day
78	5	23	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Jedrzejczak
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informan: Peter Jedrzejczak (son)
(b) Address 1212 Ellwood Avenue

17 (a) Burial (b) Date thereof 11/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Lilly & Zeile Inc
(b) Address 403 S. Broadway St

19 (a) 11 21 1948 (b)
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948, at 9.20a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George F. Weidt M.D.
Medical Examiner.
Date signed November 18, 1948

G68745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68745 61 Registered No. G68745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lin Der

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Yellow	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-18-01

8. AGE: Years	Months	Days	If less than one day
47	-	29	hr. min.

9. Birthplace Calif. (Town, county, and state)
10. Usual Occupation Laundryman
11. Industry or business

FATHER
12. Name Jum Der
13. Birthplace China

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

NOV 21 1948 (Date rec'd by registrar) [illegible], Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948, at 6 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1948 to 11-16 1948 and that I last saw him alive on 11-16 1948.

Immediate cause of death Hepatic coma — Duration

Due to Hepatic insufficiency - acute severe

Due to ? Laennec's Cirrhosis

Other Conditions Diabetes mellitus - mild.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address The Johns Hopkins Hosp. Date signed 11/17/48

VS 150

124a

G68746 B.C. 48-1998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G687466 Registered No. 111c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 LINDEN AVE.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 LINDEN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARILYN HARRISON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 15, 1948

8. AGE: Years	Months	Days	If less than one day
	2	5	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business NONE

FATHER
12. Name SOLOMON HARRISON
13. Birthplace NEW YORK CITY

MOTHER
14. Maiden Name RUTH POMERANTZ
15. Birthplace BALTIMORE MD

16 (a) Informant: ALVIN POMERANTZ
(b) Address 2244 LINDEN AVE

17 (a) BURIAL (b) Date thereof NOV. 21, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MISHKIN ISRAEL CEM.
Location SOUTHERN AVE.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

18 (c) NOV 21 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 20 1948, at 4:20 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rayon M.D.
Medical Examiner.
Date signed 21 Nov 48

VS 151

G68747 B.C. 48-21864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

✓ G68747 47
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2418 Oswego Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Handleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/48

8. AGE: Years	Months	Days	If less than one day
	1	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Norman Handleman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Leatrus Hoffman
15. Birthplace Baltimore Md.

16 (a) Informant:
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh Cem
Location Windsor Mill Rd.

18 (a) Funeral director Joseph Levin & Son
(b) Address 2106 Eutaw Place

19 (a) NOV 21 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at 7 9. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical Suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15 11 3

(a) Date of injury NOV 21 at 7. A. M.
(b) Where did injury occur? 2418 Oswego Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) No
(d) Means of injury Smothered by Crib Bumper

23. Signature Ewald L. Berg M.D.
Medical Examiner

Date signed NOV 22 1948

VS 151

G68748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68748 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hartman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife Frank Hartman
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 18, 1875

8. AGE: Years	Months	Days	If less than one day
about 73	1	1	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Starr Wheeler
(b) Address 3712 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Old Frederick Road.

18 (a) Funeral director Austin E. Donovan.
(b) Address 3638 Roland Ave.

19 (a) 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1948 to Nov. 19, 1948. and that I last saw her alive on Nov. 19, 1948.

Immediate cause of death Lobar pneumonia, left
Duration 7 days
Due to
Due to
Other Conditions Arteriosclerotic Cirrhosis, Chronic hepatitis; chronic nephritis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: none
of autopsy See Cause of death

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Swaby, Jr. M. D.
Address 1213 Light Street Date signed 11/19/48

668749

BC-48-2528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

668749
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Weiner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	—	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Philip Weiner
13. Birthplace New York.

MOTHER
14. Maiden Name Jean Peltz
15. Birthplace New York

16 (a) Informant Philip Weiner
(b) Address 2718 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21 48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Comfort
Location Germany Hill Rd.

18 (a) Funeral director Jack Levin Co
(b) Address 2100 Eutaw Pl.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1948 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-48 19 at 6 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19-1948, to 11-21-1948 and that I last saw him alive on 11-21-1948.

Immediate cause of death Bronchopneumonia — Duration

Due to Aspiration

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss M. D.
Address Sinai Hospital Date signed 11/21/48

167

68750 4P-24759 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 68750
Registered No.

CERTIFICATE OF DEATH

159E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy LEFTWICH ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
		8		

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Douglas A. Leftwich
13. Birthplace Va.

MOTHER
14. Maiden Name Anita Ethelyn
15. Birthplace Va

16 (a) Informant Mrs. D. A. Leftwich
(b) Address 1645 Eastern Ave.

17 (a) Removal (b) Date thereof Nov. 22-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Fairport, Va.

18 (a) Funeral director John E. Connolly
(b) Address 418 Eastern Ave.

19 (a) Nov 22 1948 (b) Hunting Williams, Md.
(Date received by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14-1948 to 11-21-1948, and that I last saw him alive on 11-21-1948

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia Intrauterine septal defect

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss
Address Sinai Hospital Date signed 11/22/48

VS 150

107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 68751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hosp. 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marvin Davis, Sr.

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife: Emmie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 19, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	1	hr. min.

9. Birthplace: Darlington S. Car. (Town, county, and state)

10. Usual Occupation: Restaurant

11. Industry or business: Owner

FATHER
12. Name: John C. Davis
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Henrietta Patrick
15. Birthplace: S.C.

16 (a) Informant: Mrs. Emmie Davis
(b) Address: 5605 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul Street

19 (a) NOV 22 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944, at 4 00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 18 1944 to Nov 20 1944, and that I last saw h[illegible] alive on Nov 20 1944.

	Duration
Immediate cause of death: Cardiovascular Renal disease (uremia)	1 week
Due to: Arteriosclerosis Nephritis and	?
Due to: Hypertensive cardiovascular disease with cardiac hypertrophy	?
Other Conditions: Aneurysm of Abdominal Aorta Arteriosclerosis and glaucoma	

(Diseases directly leading to death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Marvin W. Davis M. D.
Address: West Balto Gen'l Hosp Date signed: 11-20-44

VS 150

13 1a

6687:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48 B

6687:52
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4848 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4848 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA M. LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Richard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ---66666666-----

FATHER
12. Name Lawrence Wappman
13. Birthplace Md

MOTHER
14. Maiden Name M. Veters
15. Birthplace Md

16 (a) Informant Richard Lewis
(b) Address 4848 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 48 to Nov 20 19 48 and that I last saw h alive on Nov 20 19 48

Immediate cause of death: Carcinoma of uterus — Duration: 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Manuel Levin M.D.
Address 4848 Reisterstown Rd Date signed Nov 20/48

VS 15.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS CLARA FRANCIS

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: Peter E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14/1876

8. AGE: Years	Months	Days	If less than one day
72	9	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gotteimier
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Folkam
15. Birthplace Germany

16 (a) Informant Peter E. Francis
(b) Address 507 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 NOV 1948 at 1.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 01 NOV 1948 to 20 NOV 1948. and that I last saw HER alive on 20 NOV 1948.

Immediate cause of death: CARDIAC ARREST — Duration: 1 min

Due to CARDIAL HYPERTROPHY + MYOFIBROSIS — 5-10 YRS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: AUTOPSY.

or autopsy: 1) ABOVE CARDIAC DIAGNOSES 2) DIVERTICULI, ESOPHAGUS + DUODENUM 3) HEMORRHAGIC ENTEROCOLITIS

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald T. England M. D.
Address Maryland Gen Hosp Date signed 22 Nov 48

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 190

6687:54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95R

6687:54

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 St. Paul St. (If rural, give location)
(e) Citizen of foreign country? No. Yes or No
If yes, name country

3 (a) FULL NAME Mr. Thomas Julius Mohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Mabel My Mohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1902

8. AGE: Years 46 | Months 9 8 | Days 18 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name Mr. John Mohr
13. Birthplace Baltimore, Md. ~~Baltimore~~

MOTHER
14. Maiden Name Willie ~~Wallace~~ Virginia
15. Birthplace ~~Baltimore, Md.~~

16 (a) Informant Wife
(b) Address 2023 St. Paul St., Balt.

17. ~~Interment~~ Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)

(c) Cemetery or crematory Loudown
Location Woodlawn Md.

18 (a) Funeral director Gilbert Cook Co.
(b) Address 2119 St. Paul St.

19. NOV 22 1948 (Date rec'd by registrar) (S) for William H. Register

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1948 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6, 1948 to Nov 20, 1948. and that I last saw him alive on Nov. 20, 1948.

Immediate cause of death: Rheumatic Heart Disease with Mural Thrombi
Due to Myocardial Failure
Due to Multiple Pulmonary Infarctions

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: By above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hosp. Date signed 11/19/48

VS 150

6687:55

CERTIFICATE CORRECTED 9-1-50

BALTIMORE CITY HEALTH DEPARTMENT

ES-124740 **CERTIFICATE OF DEATH** 124a

6687:55 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Rosenzweiz or Harry Rosenzweig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Abraham Rosenzweiz
13. Birthplace Russia?

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levine Inc
(b) Address 2100 Eastern Ave

19 NOV 22 1948 (b) Livingston Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1948 at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-21 1948 and that I last saw him alive on 11-21 1948.

Immediate cause of death	Duration
Pulmonary edema	3 hrs.
Due to unknown cause	
Due to	
Other Conditions Cirrhosis, Laennec's severe.	1 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Weaker M D
Address Balto City Hosp Date signed Nov 22 48

VS 150

111c

Corrected Death Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68756

G68756 AC-FB-2154 157E

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Avenue

(c) Hospital or institution: Sinai Hospital of Baltimore, Inc. 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 216

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5328 Cuthbert Ave #15

(If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3. (a) FULL NAME RICHARD COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1948

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Sinai Hosp. Balto, Md. (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Frank Cohen

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Ray Rosen

15. Birthplace Baltimore, Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location

NOV 19 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Oct 6 1948, and that I last saw him alive on Oct 6 1948.

Immediate cause of death Circulatory Failure

Due to Tricuspid Stenosis

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tricuspid Stenosis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Lyndsey A. Weiden M. D.

Address Sinai Hospital Baltimore Date signed Nov 24/48

VS 150

Please write or type. Use pen and ink. Do not use pencil. Be sure that cause of death is clearly and legibly.

G687556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G687556 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Springhill Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1948

8. AGE: Years	Months	Days	If less than one day
		286	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Phillip Cohen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bernice Freedman
15. Birthplace New York

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 22 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948 to Oct 5 1948, and that I last saw her alive on Oct 5 1948.

Immediate cause of death Congenital Heart Disease Ruptured Atresia — Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ruptured atresia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney Altevogt
Address Sinai Hospital Date signed Nov 17/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66857

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. and Rutland Ave.
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 14 Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Taylor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Jackson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1948

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Jackson
13. Birthplace Baltimore

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sinai Hosp.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH June 13, 1948, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw h alive on 19

Immediate cause of death Prematurity
Hemorrhagic Diseases of Newborn
Anemia due to Chronic Loss of Blood

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney A. Warren M.D.
Address Sinai Hospital Date signed Nov 17/48

VS 150

Please write plainly with pen or typewriter. Physicians: please write the causes of death clearly and legibly.

GR-48-23768

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 68758

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc. 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Portland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Scherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Scherr
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Belkowitz
15. Birthplace New York

16 (a) Informant Rose Scherr
(b) Address 637 Portland Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Nov 3 1948, and that I last saw h/ alive on Nov 3 1948.

Immediate cause of death	Duration
Subarachnoid Hemorrhage + Prematurity	
Due to	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolmaker M. D.
Address Sinai Hosp Date signed 11/17/48

VS 256

X

G687:9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G687:9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2731 Eastern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret (Maggie) Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel Stallings
6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

MOTHER OF FATHER

12. Name Christian Timm
13. Birthplace

14. Maiden Name Margaret Haugh
15. Birthplace

16. (a) Informant John Weifenbach
(b) Address 443 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/48 (month) (day) (year)
(c) Cemetery or crematory Loraine Cem
Location Balto

18 (a) Funeral director Welch Funeral Home
(b) Address 2007 Orleans St.

19 (a) [illegible] (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948 . at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 . to Nov 19 1948 . and that I last saw her alive on Nov. 19 1948 .

Immediate cause of death — Duration

Carcinoma of Uterus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zellers, M.D.
M. D.
Address 2739 Eastern Ave. Date signed 11/29/48.

VS 150

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 68760

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)

(d) Street No. 517 N. Carey, (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby-girl Harley

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/20/48

8. AGE: Years | Months | Days | If less than one day: 3 hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Oscar Harley

13. Birthplace N. C.

MOTHER

14. Maiden Name Catherine Davis

15. Birthplace Md.

16 (a) Informant .....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory .....

Location .....

18 (a) Funeral director .....

(b) Address .....

19 NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19....., and that I last saw h alive on ..... 19 .....

Immediate cause of death Prematurity

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature A. C. Lang M. D.

Address Johns Hopkins Hosp Date signed 11-20-48

M. D. D. 1938-9

G68761 ✓ G68761

G68761 HEALTH DEPARTMENT—CITY OF BALTIMORE

BC-48-2463

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4224 6th St - St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Girl Williams

(a) Residence: No. 4224 - 6th St - St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Wh.	single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 14, 1948

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore, Md. (State or country)

FATHER

13. NAME William Robert Williams

14. BIRTHPLACE (city or town) Lieto ... U.S. (State or country)

MOTHER

15. MAIDEN NAME Mary Louise Hurt

16. BIRTHPLACE (city or town) Huntington, W. Va. (State or country)

17. INFORMANT Mrs. Mary L. Williams

(Address) 4224 - 6th St

18. BURIAL, CREMATION, OR REMOVAL

Place ... Univ. of Medical School ... NOV 16 1948 ... 19

19. UNDERTAKER Commissioner of Health

(Address)

20. FILED NOV 22 1948 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 14 ... 1948

22. I HEREBY CERTIFY, That I attended deceased from 11/14 ... 1948 to 11/14 ... 1948

I last saw her alive on 11/14 ... 19 48 Death is said to have occurred on the date stated above, at 3:30 p.m.

The principal cause of death and related causes of importance were as follows:

Premature birth — (Date of onset)

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19 ...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) ... M. D.

(Address) ...

068762 BC-48-25682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. 068762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy McCormick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Henry McCormick
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Margaret Goodwin
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. McCormick
(b) Address 32 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director James J. McCann
(b) Address 32 S. Fort Ave.

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address Franklin Square

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948, at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 11/21 1948. and that I last saw h/xx alive on 11/21 1948.

Immediate cause of death Respiratory failure

Due to Anoxia of birth.

Due to Breech Extraction Abnormal

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter K. Shelabey M.D.
Address Franklin Square Date signed 11/24/48

VS 380

68763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. 66870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME HENRY PETERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location University Medical School NOV 15 1948

18 (a) Funeral director ..... Commissioner of Health
(b) Address .....

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Strangulation
Other Conditions Chronic Alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or secondary ☐ cause of death, fill in the following:
(a) Date of injury Nov. 8, 48 ? M.
(b) Where did injury occur? 2806 N. Calvert St.
(c) Did injury occur at home, on farm, in factory, in public place? Home While at work? No
(d) Means of injury Hung self with rope on bed-

23. Signature John L. Blair M.D.
Medical Examiner.
Date signed 11/8/48

68764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178a

Registered No. 66870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 West Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE SPROLES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of Husband or wife Beulah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace U (Town, county, and state)
10. Usual Occupation N
11. Industry or business N

FATHER
12. Name N
13. Birthplace U

MOTHER
14. Maiden Name N
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 6.25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-48 at 1411 M.
(b) Where did injury occur? 807 W. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in pub place? home While at work? no
(d) Means of injury Open in adjoining room on but unlit

23. Signature Emil L. Kruger M.D.
Medical Examiner.
Date signed November 10, 1948

VS 151

68765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 68765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 St. Barnabas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Chauncey Hughes.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1902
8. AGE: Years 46 | Months | Days | If less than one day: hr min
9. Birthplace Baltimore? (Town, county, and state)
10. Usual Occupation Junk Collector.
11. Industry or business

FATHER
12. Name William Hughes.
13. Birthplace Md

MOTHER
14. Maiden Name Fanny Smith
15. Birthplace Md.

16 (a) Informant Chauncey Hughes
(b) Address 912 St. Barnabas St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 16 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10-48 19 at 3:47 M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948 to 11-10 1948 and that I last saw him alive on 11-10 1948.

Immediate cause of death Respiratory failure — Duration

Due to Postal Exhaustion

Due to chronic alcoholism Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert R. Hahn M.D.
Address University Hosp Date signed 11-12-48

VS 150

G6870-6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G6870-6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Northern Parkway
(c) Hospital or institution:

27-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Northern PKwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-5994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife OTillie K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-16-1883

8. AGE: Years	Months	Days	If less than one day
65	0	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John J. Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Rodgers
15. Birthplace Md.

16 (a) Informant Mrs. MILDRED Brady
(b) Address 2704 Northern PKwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location BALTo

18 (a) Funeral director L. J. Ruck
(b) Address 5300 HARford Road-

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw him alive on January 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Donald Landon M. D.
Address 4077 Hayford Rd Date signed 11-19-48

VS 150

Please write all entries in ink. Physicians: please write the causes of death clearly and legibly.

G68767 Bacon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68767

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hildagard (Hilda) Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife August Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 17, 1870

8. AGE:	Years	Months	Days	If less than one day
	78	3	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Pious Gutmann
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Ann T. Schmidt
(b) Address 1503 Holbrook Street

17 (a) Burial (b) Date thereof 11-24-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Nov 22 1948 (b) Huntington for Williamsport, Md.
(Filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th 1948 at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Nov. 20 1948.
and that I last saw h[illegible] alive on Nov. 20 1948.

Immediate cause of death Chr. myocarditis & arteriosclerosis and hypertension — Duration 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 11/24/48

VS 15

668768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

668768

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1858

8. AGE: Years 90 | Months - | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles King
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Virginia Victor
(b) Address 2717 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Morelands Memorial Park
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1948 to Nov 20 1948 and that I last saw him alive on Nov 20 1948

Immediate cause of death	Duration
Fecal Adenocarcinoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm J Kinnett M.D.
Address 701 N Lanvale Ave Date signed 11/22/48

VS 150

68769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ 68769 Registered No.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address 533 E. 38th St. Baltimore 18

(c) Hospital or institution: 4-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 533 E. 38th St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME James John Schuch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 7, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation watchman

11. Industry or business

FATHER 12. Name Matthias Schuch

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Wolf

MOTHER 15 Birthplace Germany

16 (a) Informant Joseph F. Schuch (Son)

(b) Address 533 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 - 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary (cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester street

19 (a) [illegible] (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 3.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1948, to 11-19 1948, and that I last saw him alive on 11-19 1948.

Immediate cause of death

Massive Pulmonary embolism Left — Duration: 5 minutes

Due to Thrombophlebitis, right leg — Duration: 5 weeks

Due to

Other Conditions hypertensive cardiovascular disease arteriosclerotic heart disease — Duration: years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pulmonary embolism

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. T. Por 3d.

Address Union Memorial Hospital Date signed 11-19-48

VS 150

100 C

G68770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-D

G68770

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Mrs.) Mamie Jackson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Albert
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr) 4-6-98
8. AGE: Years 50 | Months 7 | Days 12 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name ? Cooper
13. Birthplace ?

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-1948 (month) (day) (year)
(c) Cemetery or crematory Fort Calvary Cemetery
Location Balto Co. Md.
18 (a) Funeral director Robert E. Williams
(b) Address 1545 McElderry
19 NOV 22 1948 (Date rec'd by registrar) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1948, at 9:05 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1948, to 11/18 1948 and that I last saw her alive on 11/18 1948.

Immediate cause of death: Cerebral thrombosis — Duration
Due to: Hypertensive cardiovascular disease
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Columbella Harvey M.D.
Address John Hopkins Hospital Date signed 11-18-48

VS 159

G68771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G68771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Raspeburg, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5319 McCormick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER N. McCORMICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emily C. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11th, 1882

8. AGE: Years	Months	Days	If less than one day
66	10	10	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Holy Redeemer

FATHER
12. Name Charles McCormick
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Ella Lambright
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Carl B. Sprecher, Jr.
(b) Address 1118 Orems Road, Balto., 20

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasaah Funeral Home
(b) Address 7401 Belair Rd.

NOV 22 1948 (Date received by registrar) (b) Washington Millis, M.D.

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1948 at 3:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Mar 1948 to 21 Mar 19 ; and that I last saw h[illegible] alive on 21 Mar 1948.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Arteriosclerotic Renal Disease	
Due to Hypertension	
Other Conditions Hypertrophy Prostate & Acute Urinary retention (Include pregnancy within 3 months of death)	

Date of operation 11/11/48
Major findings of operation: Prostatic Hypertrophy
of autopsy: Arteriosclerotic Renal Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael Famiglio M.D.
Address 7616 Belair Rd. Date signed 11/24/48

8772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 12-1a

Registered No. 668772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Paramount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Paramount Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Florence A Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1875

8. AGE: Years	Months	Days	If less than one day
73	8	15	hr. min.

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation Carpenter Retired
11. Industry or business P. R. R.

FATHER
12. Name ? Johnson
13. Birthplace Norway

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Laura B. Johnson
(b) Address 4210 Paramount Ave.

17 (a) Burial (b) Date thereof Nov 22 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem
Location Taylor Ave
18 (a) Funeral director John E. Fuller
(b) Address 2224 Pennsylvania Ave.
19 (a) NOV 22 1948 (b) Catherine Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1948 to Nov 19 1948, and that I last saw h[illegible] alive on Nov 18 1948.

Immediate cause of death	Duration
Broncho Pneumonia	9 d
Uraemia	5 d
Due to Mitral Regurgitation	1 mo
Incompetence	1 mo
Due to Chr. Interstitial Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Fuller M. D.
Address 2878 Ivanhoe Rd Date signed 11-19-48

V S 150

68773 KARL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G68773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution: Church Home + Hospital Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W. Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Gunnen Leino

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of former wife Mrs. Hilja Leino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/24/87

8. AGE: Years	Months	Days	If less than one day
61	9	26	hr. min.

9. Birthplace Finland (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Karl Ekstron
13. Birthplace Finland

MOTHER
14. Maiden Name Ida Halmroos
15. Birthplace Finland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 1128 Dundalk Ave.

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 , at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1948, to 11-20 1948, and that I last saw h/ alive on 11-19 1948.

Immediate cause of death Generalized Peritonitis — Duration 3 days

Due to Leaking Appendix

Due to

Other Conditions Pulmonary atelectasis + edema

(Include pregnancy within 3 months of death)

Date of operation 11/16/48

Major findings of operation: Carcinoma of stomach

of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. T. Morrow M. D.
Address Church Home Hosp. Date signed 11-20-48

G68774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1868

8. AGE: Years	Months	Days	If less than one day
80	--	6	hr. min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Roberts
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Griffiths
15. Birthplace Wales

16 (a) Informant Mr. J. F. Thrift
(b) Address 2809 Mt. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 22 1948

VS (59)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to 11/18 1948, and that I last saw h[illegible] alive on 11/4 1948.

Immediate cause of death: Paralysis flaccid due to metastatic carcinoma. — Duration: 3 weeks.
Due to: Carcinoma ileum r/s
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2/11/48.
Major findings of operation: Biopsy — non diagnostic
of autopsy: 11/20/48 - Partial.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Lauer, M. D.
Address Medical Arts Bldg. Date signed

For Henry F. Lauer X

668775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668775 Registered No. 122a

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or [redacted] St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mary Kinzer

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Albert J. Kinzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 29, 1883

8. AGE: Years 65 | Months 6 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frisby Lloyd
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Lynch
15. Birthplace Unknown

16 (a) Informant Miss Margaret Kinzer
(b) Address 2407 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Harrington's
(b) Address 2024 Orleans St.

19 NOV 22 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1948 to Nov. 21, 1948, and that I last saw her alive on Nov. 21, 1948

Immediate cause of death	Duration
Hypostatic Pneumonia.	
Due to Chronic Peritonitis	
Due to Incarcerated Hernia. & dehiscence of Repair	
Other Conditions Hypertensive C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation 10/26/48
Major findings of operation: Incarcerated. Ventral hernia & Umbilical Hernia
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature John T. Everett M.D.
Address St. Joseph's Hosp. Date signed 11/21/48

VS 189

68776 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 68776

CERTIFICATE OF DEATH

93

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 N. Linwood Ave Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Wm. A. Bell

If U. S. Veteran specify WAR

(a) Residence: No. 1423 N. Montford Ave St., 8-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Georgie Bell

6. DATE OF BIRTH (month, day, year) April 2nd 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Henry Thomas Bell

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Mary E. Askew

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Benson Waldman

(Address) 4528 Marble Hall Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Oak Lawn Date Nov 24th 1948

19. UNDERTAKER Leo G. Cook

(Address) 1701-03 N. Patterson Park Ave

20. NOV 22 1948 Contagion Williams Jr

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) NOVEMBER 21, 1948

22. I HEREBY CERTIFY, That I attended deceased from JULY, 1948 to NOVEMBER, 1948

I last saw him alive on NOVEMBER 14 1948. Death is said to have occurred on the date stated above, at 6:00 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Failure	
Arteriosclerotic Cardio-Vascular disease.	

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Peter F. Polk M. D.

(Address) 7200 Fallon Ave

G68777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G68777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 ENSOR STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr. 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 ENSOR ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL LYNN HOWARD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 24, 1865

8. AGE: Years	Months	Days	If less than one day
83	11	27	hr. min.

9. Birthplace LEEDS, NEW YORK (Town, county, and state)
10. Usual Occupation WEAVER
11. Industry or business

FATHER
12. Name HYLAND W. HOWARD
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name CATHERINE HOLLANDBECK
15. Birthplace UNKNOWN

16 (a) Informant ESTHER BROWN TAYLOR
(b) Address 1715 ENSOR STREET

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof Nov. 23-1948 (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park Cemetery

18 (a) Funeral director Joseph FARACE Inc.
(b) Address 2013 GREEN MOUNT AVE.

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May. 10, 1948, to Nov. 24 1948, and that I last saw her alive on Nov. 24 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 4 months

Due to ✓

Due to ✓

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) ✓ (County) ✓ (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Francis X. Ogden M. D.
Address 2701 N. Calvert St Date signed Nov. 24 48

VS 150

X

G68778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 4 a

G68778

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 S. Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Gajdzicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josefa

6 (c) If (a) give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Carroll Gajdzicki
13. Birthplace Poland

MOTHER
14. Maiden Name Prenta
15. Birthplace Poland

16 (a) Informant Jozefa Gajdzicki
(b) Address 322 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) NOV 22 1948 (month) (day) (year) registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20 1948, at 4 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26/48 to 11/8 1948 and that I last saw h[illegible] alive on 11/8 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to arterio-sclerosis with hypertension	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patt. Pl. Ca. Date signed 11/22/48 M.D.

VS 150

8779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G68779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 546-St. Mary's Sff.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 546-St. Mary's Sff. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Lee Perry.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-1926

8. AGE: Years 22 Months Days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation unemployed.
11. Industry or business

FATHER
12. Name Charles Perry
13. Birthplace Ga. ?

MOTHER
14. Maiden Name Lelia ?
15. Birthplace S. C.

16 (a) Informant Lelia Perry
(b) Address 546-St. Mary's Sff.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location A. Halstead

18 (a) Funeral director
(b) Address 916 Penna Ave

19 (a) NOV 22 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19- 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1948 to 11-19 1948 and that I last saw h alive on 11/17 1948.

Immediate cause of death: Pulmonary TBC — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Calvin B. LeCompte M.D.
Address 1113 H Cathedral Date signed 11/20/48

668780 Vol 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 C

Registered No. 668780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 E Biddle St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 E. Biddle St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie Shelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 7-18-04

8. **AGE:** Years: 44 | Months: 4 | Days: 1 | If less than one day: hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Buttler
13. Birthplace S.C.

MOTHER
14. Maiden Name Katie Dean
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm J Jackson
(b) Address 944 Lemmon Ave Huntington Station, Md

19 (a) NOV 22 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 11-19- 1948, at 320 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1948 to 11-19 1948, and that I last saw her alive on 11-19- 1948

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Small granular kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - (Specify type of place) While at work?
(e) Means of injury -

23. Signature Jewell Collins Harvey M.D.
Address Johns Hopkins Hospital Date signed 11-19-48

VS 150

G68781 4

ES-126719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 82a

Registered No. G68781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 16 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Emma Ellison

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1890

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 844 Penna ave

19 NOV 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1948 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-20 1948, and that I last saw her alive on 11-20 1948.

Immediate cause of death Bronchopneumonia, bilat. — Duration
Due to recent cerebral accident
Due to arteriosclerosis & hemiplegia, rt.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William H. Vickers J.
Address Balto City Hosp. Date signed 21 Nov 48.

VS 150

668782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 657 Sterling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 657 Sterling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Doctrins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice Doctrins

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 18-1894

8. AGE: Years 54 | Months 57 | Days 4 | If less than one day: hr. min.

9. Birthplace Club Hill Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Doctrins

13. Birthplace Eastern Shore Md

MOTHER 14. Maiden Name Hanna Barnes

15. Birthplace Wayford Co. Md

16 (a) Informant Alice Doctrins

(b) Address 657 Sterling St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 22-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem.

Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Bentley ave

19 (a) Date received NOV 22 1948 (b) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 2:30 P.M. at

21. I certify that deceased died on the date above stated; that I attended deceased from 10-20 48 to 11-18 48. and that I last saw h[illegible] alive on 11-18-48.

Immediate cause of death: (a) Bronchial Pneumonia — Duration 4 wks

Due to: (b) Secondary Anemia

Due to: (c) Stroke — 8 wks.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Baker M. D.

Address 1603 N. Caroline Date signed 11/20/48

VS 150

G68783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G68783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 N. Montford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KONSTANTY NASURO

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Stanislawa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 24, 1873

8. AGE: Years	Months	Days	If less than one day
74	10	25	hr. min.

9. Birthplace Wilno, Poland
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Retired

FATHER
12. Name Mikolaj Nasuro
13. Birthplace Wilno, Poland

MOTHER
14. Maiden Name Petronella Byslak
15. Birthplace Poland

16 (a) Informant Mr. Matthew Nasuro
(b) Address 14 N. Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) Nov 22 1948 (b) Washington Williams, M.D. Registrar
Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 5 45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 18 1948 to Nov 19 1948, and that I last saw him alive on Nov 18 1948

Immediate cause of death	Duration
Senile Cardiac	
Due to Arteriosclerosis	2 Hrs
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roscoe E. Linsenmeyer M. D.
Address 1408 Maryland Ave Date signed 11-20-48

95c

G68784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G68784 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Maggie Jones.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr) March 10, 1885.

8. AGE: Years 63 | Months 8 | Days 10 | If less than one day: hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Jones.
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Priscilla Moore.
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Maggie Jones.
(b) Address 616 Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

NOV 22 1948 (Date received by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20 1948 at 5C. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1948 to NOV. 20 1948.
and that I last saw h[illegible] alive on NOV. 20 1948.

Immediate cause of death: Congestive Heart Failure
Due to: T.B. Peritonitis
Due to:
Other Conditions
(include pregnancy within 3 months of death)

Duration: 6 mo's

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed [illegible]

VS 150

G68785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Foster Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Foster Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET C. McCORD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George W. McCord
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/2/1887

8. AGE: Years	Months	Days	If less than one day
61	2	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Frederick Kegel
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara ?
15 Birthplace Maryland

16 (a) Informant Ida Albert
(b) Address 2435 Foster Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 23 (day) 48 (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave. Balto.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31, Md.

19 (a) (Date received by registrar) (b) [illegible] Registrar

NOV 22 1948

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 20 1948, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 48 to Nov. 20 19 48 and that I last saw her alive on Nov. 20 19 48.

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Arterio- sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Agnes Zeller, M. D.
Address 2739 Eastern Ave. Date signed 11/22/48 M. D.

668786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 668786

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Balls-Payson-Fayette Sts

(c) Hospital or institution: Bon Secours 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6119 Pimlico Rd (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Casimer Witkowski (CASIMIR FELIX WITKOWSKI)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caroline V. Witkowski

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 21 1883

8. AGE: Years 64 | Months 11 | Days 39 | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Prof of Business

11. Industry or business Training Institute

FATHER — 12. Name Thos. Witkowski

13. Birthplace Poland

MOTHER — 14. Maiden Name Cecilia T ?—

15. Birthplace Poland

16 (a) Informant Mrs Caroline V. Witkowski

(b) Address 6119 Pimlico Rd (wife)

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov 23 45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore.

18 (a) Funeral director Stewart Mortuary

(b) Address 128 W Lanvale

(a) NOV 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 1948 to 11/20 1948.

and that I last saw him alive on 11/19 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Cong. Heart disease	
Due to Rheumatic heart disease	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature D Schuhler

Address Bon Secours Hosp Date signed 11/20/48 M. D.

X

VS 150

#24 4W SC-48-12862 ✓ G68787

G68787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96 Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 5 MO.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Talbot Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Richard Edward Burke

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	CHILD

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-20-48

8. AGE: Years	Months	Days	If less than one day
	5	-	hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business ..

FATHER
12. Name William Burke
13. Birthplace Md

MOTHER
14. Maiden Name Norma Walsh
15. Birthplace Md

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof 11-23-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN MD.

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2200 ERMONDSON AVE.

19 (a) ..... (b) .....
(Date received by registrar) Registrar

NOV 22 1948
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17-1948 to 11-20-1948, and that I last saw him alive on 11-20-1948.

Immediate cause of death: intra-cranial hemorrhage
Due to: 1 aneurysm
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 11/22/48

668788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

668788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Genl DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town English Consul (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Alderwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos R. Heller

3 (b) If veteran, name war: World No. 1

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henrietta Heller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1878

8. AGE: Years 69 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Highway Dept. Balto. City

FATHER
12. Name Cyrus Heller
13. Birthplace W. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant: Mrs. Henrietta Heller
(b) Address 2736 Alderwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 22 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1948, at 1145 M

21. I certify that I took charge of the remains described above, held an Org Ed Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? Where at (City)
(d) Means of injury

23. Signature William G Helfrich M.D.
Medical Examiner.
Date signed 11/20/48

S 151

G68789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Bonner Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Bonner Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELIA M. FUHRMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife George A. Fuhrman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1858

8. AGE: Years	Months	Days	If less than one day
90	0	20 21	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Josiah Babylon
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Haefley
15. Birthplace Md.

16 (a) Informant Miss Grace P. Fuhrman
(b) Address 3806 Bonner Rd.

17 (a) Burial (b) Date thereof 11/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Krieder's Cem.
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 22 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948 at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to [illegible] and that I last saw h[illegible] alive on [illegible]

Immediate cause of death	Duration
[illegible]	[illegible]
Due to [illegible]	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

668790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 668790 Registered No. 1562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3231 Normount Ave.
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3231 Normount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN MILLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-03-9957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hedwig F. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1903

8. AGE: Years	Months	Days	If less than one day
45	6	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Miller Bros.

FATHER
12. Name Ferdinand Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Fredersdorff
15. Birthplace Germany

16 (a) Informant Mrs. Hedwig F. Miller
(b) Address 3231 Normount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11/22/48 (b) [illegible] for Williams M.D. Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 1948, to Nov 20 1948, and that I last saw h[illegible] alive on Nov 19 1948.

Immediate cause of death	Duration
[illegible]	about 3 yrs.
Due to	
Due to [illegible]	for [illegible] about 1 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

Cube 668791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164c

668791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JANE CHARLOTTE CULVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel H. Culver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1909

8. AGE: Years 39 | Months 9 | Days 23 | If less than one day: hr. min

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sterling K. Collier
13. Birthplace Petersburg, Va.

MOTHER
14. Maiden Name Lula May Fisher
15. Birthplace Piedmont, W. Va.

16 (a) Informant Dr. Samuel H. Culver
(b) Address 5611 Pimlico Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month, day, year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 22 1948 (Date rec'd by registrar) (b) Huntington Hollow Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound, .38 Revolver
Right Temple

Due to

Other Conditions Marked Mental Depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/20/48 at 4:55 P.M.
(b) Where did injury occur 5611 Pimlico Road
(c) Did injury occur at home, on farm, industrial place, in public place) Home (Specify)
(d) Means of injury Self Inflicted

23. Signature John L. D'Aura M.D.
Medical Examiner.
Date signed 11/21/48

VS 151

668792

377508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town LAWRENCE, (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 LAWRENCE, AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celeste Thomas (Celesta)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife Samuel Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-97

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	11	17		

9. Birthplace Ga. (Town, county, and State)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Ernest Tabront
13. Birthplace N. C.

MOTHER
14. Maiden Name Lillie Armstrong
15. Birthplace Ga.

16 (a) Informant: records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Greenville
Location Hampstead Long Island N.Y.

18 (a) Funeral director Wm. S. Nelson
(b) Address 1303 Eastman Ave

19 NOV 22 1948 (Date rec'd by Registrar) (b) Huntington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 20 - 48 at 1 9a A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-7- 1948 to 11-20- 1948 and that I last saw her alive on 11-20- 1948.

Immediate cause of death	Duration
CARCINOMATOSIS	9 mos
Due to CARCINOMA BLADDER INFILTRATING	9 mos
Due to	
Other Conditions Hydronephrosis	

(Include pregnancy within 3 months of death)

Date of operation APRI 1948
Major findings of operation: CARCINOMA BLADDER
of autopsy GENERALIZED Metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Rivera Hanson, M.D.
Address Johns Hopkins Date signed 11-21-48 (M.D.)

VS 153

G68793 PAIKOWSKY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68793

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Abraham Paikowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color of race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name John Paikowsky

13. Birthplace Russia

MOTHER

14. Maiden Name Jennie Williams

15. Birthplace Russia

16 (a) Informant Dr Hyman L Paikowsky

(b) Address 7 Wilson Park WaterVille Maine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23, 1948 (month) (day) (year)

(c) Cemetery or crematory Portland Maine

Location Maine

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1948 at 11 P M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-8-1948 to 11-21-1948, and that I last saw him alive on 11-21-1948

Immediate cause of death Acute myocardial infarction — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Sinai Hosp. Date signed 11-21-48 M. D.

VS 150

68794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 68794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME GILBERT ROSEVELT BROOKS

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
41			..... hr. ..... min.

9. Birthplace Brokenberg, Virginia
(Town, county, and state)
10. Usual Occupation maintenance man
11. Industry or business Rheem Manufacturing Co.

FATHER
12. Name Ozie Brooks
13. Birthplace Brokenberg, Va.

MOTHER
14. Maiden Name Daisey Hairfield
15. Birthplace Brokenberg, Va.

16 (c) Informant Venton Hairfild
(b) Address 1515 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Family Cemetery
Location Brokenberg, Va.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hgts. Ave.

NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1948, at 9.45a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....

Coronary Arteriosclerosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature Thos. E. Merrill M.D.
Medical Examiner.
Date signed November 22, 1948

VS 151

G68795

JL - 65255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G68795
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Fainter (Francis F.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ada
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, ?187?

8. AGE: Years	Months	Days	If less than one day
77 ?	9	27	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Fainter
13. Birthplace Va.

MOTHER
14. Maiden Name Bridget
15. Birthplace Ireland

16 (a) Informant B. C. H. Records.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Washington, D. C.

18 (a) Funeral director Stephen J. Fleming
(b) Address 1436 Eight St. S.E. Dist 30

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948, at AM 7.52 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1941 to Nov. 21 1948. and that I last saw him alive on Nov. 21 1948.

Immediate cause of death: Postmortem myocardial infarction — Duration 2 hrs

Due to Arteriosclerotic Heart Disease.

Due to

Other Conditions Nephrosclerosis

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Hinkins M. D.
Address Balt City Hosp Date signed Nov 22

VS 150

921

68796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 68796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 45
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 S. LINWOOD AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MINNIE WILHELMINA HANES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WID.

6 (b) Name of husband or wife: Philip Hanes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1, 1885

8. AGE: Years: 63 | Months: 10 | Days: 13 | If less than one day: hr. min.

9. Birthplace: BALTO. MD. (Town, county, and state)

10. Usual Occupation: HWFE.

11. Industry or business

FATHER 12. Name: Henry Schoenfelder

13. Birthplace: Balto Md.

MOTHER 14. Maiden Name: Lena

15. Birthplace: Baltimore Md.

16 (a) Informant: PATIENT

(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23/48 (month) (day) (year)

(c) Cemetery or crematory: Mt Carmel Cemetery

Location: O'Donnell St.

18 (a) Funeral director: John J. Duda

(b) Address: 2829 Hudson St.

19 (a) NOV 22 1948 (registrar) (b) Huntington Williams, Mc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 · 1948 at 9 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948 to 11-19 1948 and that I last saw her alive on 11-19 1948

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration: 3 DAYS

Due to: HEPATO-RENAL SYNDROME — 3 WKS.

Due to: CARCINOMA OF LIVER

Other Conditions: CHOLECYSTITIS with STONES. PULMONARY INFARCTION

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CANCER OF LIVER

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Krejci M. D.

Address 1400 N. Caroline St. Date signed 11-20-48

VS 159

G68797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G68797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Exton st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Formica

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-03-0567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	

6 (b) Name of husband or wife: Janet Formica
6 (c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr): 11-26-94

8. AGE: Years	Months	Days	If less than one day
53	11	23	hr. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Italy

MOTHER
14. Maiden Name: ?
15. Birthplace: Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location Frederick Ave
18 (a) Funeral director Wendell J. Wiegel
(b) Address 312 S. Highland Ave
19 (a) NOV 22 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 9.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1948, to 11-19 1948, and that I last saw h[illegible] alive on 11-19 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	2 wks
Due to Miliary Tuberculosis	2 wks
Due to Pulmonary Tuberculosis	10 mo
Other Conditions Tuberculous otitis, prostatitis, peritonitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Tuberculosis Miliary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address 601 N. Broadway Date signed Nov 22 1948
Johns Hopkins Hosp.

VS 150

G68798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G68798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.O.A.
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore Co. (If outside city or town limits, write RURAL and give county)
(d) Street No. 3657 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LAURETTE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 14 1884

8. AGE: Years 64 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace CANADA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name UNKNOWN
13. Birthplace CANADA.

MOTHER 14. Maiden Name UNKNOWN
15. Birthplace CANADA

16 (a) Informant ROBERT NELSON
(b) Address 3657 OLD YORK RD.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory AMELIA COURT HOUSE
Location AMELIA Co. VIRGINIA

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948 at 12 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Friedman M.D. Medical Examiner.
Date signed 11/22/48

VS 151

68799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 68799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3102 Chesterfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE E. HILDEBRAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jacob B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1850

8. AGE: Years	Months	Days	If less than one day
98	10	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Whiteley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Shipley
15 Birthplace Baltimore, Md.

16 (a) Informant George W. Pitt Sr.
(b) Address 3102 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1948 to Nov 20 1948, and that I last saw her alive on Nov 20 1948.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerosis

Due to Chronic myocarditis

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Charles A. Andrews M. D.
Address 3001 Fairmount Ave. Date signed Nov 22-48

VS 150

G68800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51R

G68800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Woodbrook Ave
(c) Hospital or institution: 12 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Markowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, state and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Israel
13. Birthplace Russia

MOTHER 14. Maiden Name Grena
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Druidsar Hill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2126 Eutaw Place

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1948 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to Nov 21 1948 and that I last saw him alive on 11-21 1948

Immediate cause of death: Acute coronary Thrombosis — Duration 1 day

Due to Arteriosclerosis — 20 yrs

Due to

Other Conditions — 6 weeks

Carcinoma prostate (Include pregnancy within 3 months of death)

Date of operation Sept 10, 1948

Major findings of operation: Ca of prostate

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Gross M. D.

Address 2424 Eutaw Place Date signed 22 Nov 48

VS 150

G8801 BC-XP-2375 ✓ G8801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. G8801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 949 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIANA LYNN SLOAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1948

8. AGE: Years	Months	Days	If less than one day
	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clyde J. Sloan
13. Birthplace Va.

MOTHER
14. Maiden Name Angelina Herd
15. Birthplace 949 W. Lombard

16 (a) Informant Mr. Clyde A. Sloan
(b) Address 949 W. Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmonson & Longwood

18 (a) Funeral director John J. Cowan
(b) Address 901-03 Hollins

19 (a) NOV 22 1948 (Date received by Registrar) (b) Huntington Wellington, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948, at 6:45PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Malnutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Since birth ? at M.
(b) Where did injury occur? 949 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Negligence

23. Signature [signature] M.D. (Medical Examiner)
Date signed 11/22/48

X

68802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Leeds St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Leeds St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve L. Fuller

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th 1854

8. AGE: Years	Months	Days	If less than one day: hr.	min.
94	1	6		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name John Meisel
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md.

16 (a) Informant Mr Thomas J. Fuller
(b) Address 3112 Leeds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gowen & Son
(b) Address 901-03 Hollins St.

NOV 23 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22nd 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to 11/22 1948, and that I last saw her alive on Dec 11 1947

Immediate cause of death: Arteriosclerosis Cerebral thrombosis and softening of brain — Duration: 1 yr.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Uelsk, Jr. M.D.
Address 122 E Wash Blvd Date signed 11/24/48

VS 150

688803 CERTIFICATE CORRECTED 2-9-49.

BALTIMORE CITY HEALTH DEPARTMENT ✓ 688803

B.C. 48-28945

CERTIFICATE OF DEATH

6512 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Mercy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Lee Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-28-1948

8. AGE: Years | Months 9 | Days 23 | If less than one day hr min.

9. Birthplace Md. (Town, county and State)

10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name David Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Isabelle Gray
15. Birthplace Va.

16 (a) Informant David Taylor
(b) Address 1416 - Mercy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Calvary

18 (a) Funeral director A. Hallstead
(b) Address 918 - Reid Hill

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 48, at 3.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-15 19 to 3-30 19 and that I last saw her alive on Nov. 19 19

Immediate cause of death (a) Pulmonary Edema and Emphysema — Duration 2 days

Due to (b) Acute Bronchopneumonia

Due to (c)

Other Conditions Hemorrhagic Nephritis and Endocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature St. Elmo Lacy, Jr. M.D.
Address Provident Hosp. Date signed 11-22-48

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 159

107

G68804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. West St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ella Amelia Gottlieb (Gottlieb)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	MARRIED

6 (b) Name of husband or wife: LEWIS GOTTLEIB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 21 1879

8. AGE: Years	Months	Days	If less than one day
69	3	1	hr. min.

9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business

FATHER
12. Name: JULIUS KIRCHNER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ANN A BROWN
15. Birthplace: GERMANY

16 (a) Informant: ELLA A GOTTLEIB
(b) Address: 720 W WEST ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV-26-48 (month) (day) (year)
(c) Cemetery or crematory: GLEN HAVEN CEM
Location: GLEN BURNIE MD

18 (a) Funeral director: Bernard E Hurle
(b) Address: 121 E West St

19 (a) NOV 28 1948 (Date) (b) by (Registrar) Registrar Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct. 1948, to 22 Nov. 1948, and that I last saw her alive on 22 Nov. 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs.
Due to Hypertension	6 mo?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John Robert Shell M.D.
Address Mercy Hospital Date signed 22 Nov. 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68805

161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lake Shore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena P. O.
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1948

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Keiran Holmes
13. Birthplace

MOTHER
14. Maiden Name Margaret Ann Riplinger
15. Birthplace North Vernon, Ind.

16 (a) Informant MR. HUGH - HOLMES
(b) Address LAKE SHORE, MD.

17 (a) BURIAL (b) Date thereof 11-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL.
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT & 20ND

19 (a) NOV 23 1948 (b) [illegible]
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 9:15 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 11/17 1948 to 11/22 1948 and that I last saw him alive on 11/22 1948

Immediate cause of death	Duration
Respiratory Obstruction	5 days
Due to Atelectasis, left	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature James L. Hoodle M.D.
Address St. Joseph's Date signed 11-22-48

VS 150

68806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 68806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Glyndon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1309 Glyndon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. CAVEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-09-8289

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	9	28	hr. min.

9. Birthplace Frederick, Maryland (Town, county, and state)
10. Usual Occupation Operator, retired
11. Industry or business

FATHER
12. Name Arnold P. King
13. Birthplace Md

MOTHER
14. Maiden Name Julia (Unknown)
15. Birthplace Md

16 (a) Informant John A. Cavey
(b) Address 1309 Glyndon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 23 1948 (Date rec'd by registrar) (b) Interator Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948 19 . at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 19 46 to Nov. 21 19 48. and that I last saw her alive on Nov 21 19 48.

Immediate cause of death Hypertensive Cardiov Vasculer - Renal Disease — Duration 3 years
Due to Arteriosclerosis
Due to
Other Conditions Chronic Nephritis — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John P. Ulrich, Jr
Address 1227 Wash Blv'd Date signed 11/22/48 M D

VS 150

55807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 168807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Presbury St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Presbury St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cameron Fitzhugh Bayrle

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ William C. Bayrle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 5, 1892

8. AGE: Years	Months	Days	If less than one day
56	9	16	hr. min.

9. Birthplace Culpepper, Va.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name William DeHart Fitzhugh
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Grayson
15. Birthplace Culpepper, Va.

16 (a) Informant William C. Bayrle
(b) Address 3201 Presbury St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 8.00

20. DATE OF DEATH November 21, 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1944 to 11/21 1948.
and that I last saw her alive on 11/20 1948.

Immediate cause of death Coronary occlusion — Duration 3 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter
Address 34 of Windsor Ave. Date signed 11/22/48
M. D.

VS 150

68808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G68808
Registered No.

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Ages, if not definitely known, should be carefully approximated. Entries must be made in ink. Use only standard abbreviations. Cemetery supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 N. Pulaski St.
(c) Hospital or institution:

15-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRED MILTON TRESCHLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Rose Treschler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1893.

8. AGE: Years	Months	Days	If less than one day
55	1	12	hr. min.

9. Birthplace Switzerland.
(Town, county, and state)
10. Usual Occupation Automobile Salesman.
11. Industry or business

FATHER
12. Name ? Treschler.
13. Birthplace Switzerland.

MOTHER
14. Maiden Name Marie Wasser,
15. Birthplace Switzlerland.

16 (a) Informant Mrs. Rose Treschler,
(b) Address 2215 N. Pulaski St.

17 (a) Cremation (b) Date thereof 11/23/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral director Marcel Lamaison-Law
(b) Address 1902 Eutaw Place.

19 NOV 23 1948 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st. 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 19-7 to Nov 21 19-8 and that I last saw h-- alive on Nov 18 1948.

Immediate cause of death	about	Duration
Cardio occlusion		1 hr.
Due to Cardiovascular disease		about 1 year
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunter Williams M. D.
Address 2220 Garrison Blvd. Date signed NOV 24

VS 150

68809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 668809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Foot of Anne St.
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 Oxford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM L BURTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	married

6 (b) Name of husband or wife Estella Burton

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Estella Burton
(b) Address 542 Oxford Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-23-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue

19 (a) NOV 23 1948 (Date received by Registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 19 48 at 6.45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury Found: 11-22-48 at 6.45 a. M.
(b) Where did injury occur? Found Foot of Anne St.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? ?
(d) Means of injury Found Drowned

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed November 2, 1948

VS 181

68810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68810

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2249 N. Pine St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2249 N. Pine St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** George Washington Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary Gibbs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1903

8. AGE: Years	Months	Days	If less than one day
45	5	23	hr. min.

9. Birthplace Woodhaven N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name James Gibbs

13. Birthplace Jamaica W. Indies

MOTHER

14. Maiden Name Irene ?

15. Birthplace N. C.

16 (a) Informant Mary Gibbs

(b) Address 2249 N. Pine St.

17 (a) Burial (b) Date thereof Nov. 22, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) NOV 22 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1948 at 10:58 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/48 to 11/20 1948.

and that I last saw him alive on 11/19 1948.

Immediate cause of death Intermediate Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm Garner

Address 213 Green St Date signed 11/22/48

Garner X

VS 150

68811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5414 Dennmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5414 Dennmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. James W. Boston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Bessie Boston.
6 (c) if alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1888.

8. AGE: Years	Months	Days	If less than one day
60	9	25	hr. min.

9. Birthplace West River, Md.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Richard R. Boston.
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Johnson.
15. Birthplace Md.

16 (a) Informant Bessie Boston.
(b) Address 5414 Dennmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 323 N. Schroeder St.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1948. at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948. to 11-19 1948. and that I last saw h/2 alive on 11-19 1948.

Immediate cause of death Acute Coronary occlusion — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1349 Pennsa Ave Date signed 11/22/48 M. D.

VS 150

68812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. 68812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Salem St. 2534
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALTON SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Mae Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1910

8. AGE: Years 38 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Greenville, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Greenville, S.C.

MOTHER
14. Maiden Name Maggie
15. Birthplace Greenville, S.C.

16 (a) Informant: Ella Mae Smith
(b) Address 2534 Salem St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenville S. C,
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Longwood St. Huntington Williams, Md.

19 (a) NOV 22 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 20, '48 Approx. 7:15 P.M.
(b) Where did injury occur? 2448 Francis St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Emil Rzg M.D.
Medical Examiner
Date signed 11/22/48

VS 151

X

68813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 68813

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Lombard Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2422 Frances St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Too Good

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife John Toogood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 28, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	7	23		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob ?

FATHER 13. Birthplace A.A. Co. Md.

MOTHER 14. Maiden Name Frances ?

MOTHER 15. Birthplace Md.

16 (a) Informant Margaret Green

(b) Address 1422 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Peter R. Williams

(b) Address 322 N. Schroeder St

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 . at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 15 1948 to NOV 20 1948 and that I last saw her alive on NOV 20 1948

Immediate cause of death Cardiac Failure — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/18/48

Major findings of operation: Acute cholecystitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank E Brumback M. D.

Address University Hosp Date signed 11/20/48

VS 150

68814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. 68814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 W. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 W. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT AQUILLA BRAXTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Roberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 12, 1905

8. AGE: Years	Months	Days	If less than one day
43	4	8	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name George Braxton
13. Birthplace Virginia

MOTHER
14. Maiden Name Maude Hooker
15. Birthplace Virginia

16 (a) Informant Mrs. Maude Braxton
(b) Address 523 N. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Maryland

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

a/

20. DATE OF DEATH November 21, 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948 to Nov 21 1948.
and that I last saw him alive on Nov 20 1948

Immediate cause of death Pulmonary Tuberculosis — Duration Dying indefinite

Due to

Due to

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Garland Ghisell M. D.
Address 1534 Druid Hill Ave Date signed Nov 22

VS 150

G68815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G68815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PHILLIP DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Cornelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1870

8. AGE: Years	Months	Days	If less than one day
78	7	13	hr. min.

9. Birthplace Oxford, N.C.
(Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name James Daniels
13. Birthplace Oxford, N.C.

MOTHER
14. Maiden Name Esther ?????
15. Birthplace North Carolina

16 (a) Informant Mrs. Minnie Smith
(b) Address 912 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION p/

20. DATE OF DEATH November 21, 1948 12:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 12 1948 to Nov 21, 1948 and that I last saw him alive on Nov 21 1948

Immediate cause of death Cerebral Hemorrhage — Duration 9 days

Due to Hypertension Cardio-Vascular Renal

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 803 [illegible] Date signed 11-22-48

VS 150

68816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

68816
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA ROBINSON WHITE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1858

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90	1	22		

9. Birthplace Warrenton, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elzey Robinson
13. Birthplace Warrenton, Va.

MOTHER
14. Maiden Name Lucy Ball
15. Birthplace Warrenton, Va.

16 (a) Informant Mrs. William H. White
(b) Address 2319 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 8/

20. DATE OF DEATH November 22, 1948, at 5:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1, 1948, to Nov 22, 1948, and that I last saw her alive on Nov 20, 1948

Immediate cause of death: Arteriosclerosis — Duration
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 Druid Hill Ave Date signed 11-22-48

VS 193

68817 ✓ 68817

BALTIMORE CITY HEALTH DEPARTMENT

LCH

CERTIFICATE OF DEATH 128

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1419 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BAILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/24/1882

8. AGE: Years	Months	Days	If less than one day
66	7	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levin Bailey
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Pipkett
15. Birthplace Maryland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Nov. 24, '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hohland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 19 48 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/ 19 48 to 11/20 19 48
and that I last saw h im alive on 11/20/ 19 48

Immediate cause of death
Fibro caseous tuberculosis of upper lobe

Due to

Due to

Other Conditions Hypertensive Heart Disease
(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Watkins M. D.
Address Balto City Hosp Date signed 21 Nov 48

VS 150

66818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

66818 Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Roslyn Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Burall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1864

8. AGE: Years	Months	Days	If less than one day: hr.	min
84	2	3		

9. Birthplace New London, Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Locomotive Engineer
11. Industry or business retired 18 yrs.

FATHER
12. Name Oliver Burall
13. Birthplace New Market, Fred. Co., Md.

MOTHER
14. Maiden Name Annie E. Gray
15. Birthplace New Market, Fred. Co., Md.

16 (a) Informant Miss Helen M. Burall
(b) Address 2215 Roslyn Ave.

17 (a) Burial (b) Date thereof 11-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 23 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1948 to Nov 21 1948 and that I last saw ... alive on Nov 21 1948

Immediate cause of death

Due to Renal Insufficiency — Duration 2 wks

Due to Prostatism — 2+ yrs

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard, M.D.
Address 2925 N. Charles St. Date signed 22 Nov 48

VS 150

68819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. 68819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St. Joseph's Hospital. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 49years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gordon Sutton Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/6/96

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	4	15		

9. Birthplace Kansas City, Kansas. (Town, county, and state)

10. Usual Occupation Foreman - N.B.C. Steamship

11. Industry or business Line.

FATHER
12. Name John Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Davis
15. Birthplace Baltimore

16 (a) Informant Mrs. Carl Working
(b) Address 1147 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

NOV 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948, at 5:57 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/48 19... to 11/21/48 19...
and that I last saw him alive on 11/21/48 19...

Immediate cause of death	Duration
Cardiac respiratory failure	
Due to Pneumonia,	
Due to Post. P. Abdominal wound of entrance	
Other Conditions Cancer of rectum.	

(Include pregnancy within 3 months of death)

Date of operation 11/11/48

Major findings of operation: Cancer of rectum.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carlton A. Rodgers M.D.
Address St. Joseph's Hospital Date signed 11/21/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G68830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3348 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN E. HOOD

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3784

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mabel F. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	7 6	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Holmes Thomas Hood
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Hannah Catherine White
15. Birthplace Baltimore County

16 (a) Informant Mrs. Mabel F. Hood
(b) Address 3348 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-24-48 (month) (day) (year)
(c) Cemetery or crematory St. Marys (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3611 Falls Rd. Baltimore Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 19 48 at 11 58 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 19 48 to 11-21- 19 48 and that I last saw him alive on 11-21- 19 48.

Immediate cause of death Cardiac failure — Duration

Due to Post operative pneumonia 4 days

Due to Gen arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Mercy Hosp. Date signed 11-24 M.D.

VS 150

68821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 668821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 North Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 North Pulaski Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FENA FISCHER

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife BERHARDT-FISCHER
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) Apr. 10-1863

8. AGE: Years	Months	Days	If less than one day
85	6 7	1 9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife At
11. Industry or business Home

FATHER
12. Name ? Clemer-
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Lena Fischer
(b) Address 2101 N. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 23 Nov. 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. NIPPERT & SON
(b) Address 13000 EUTAW PLACE 17

19 (a) NOV 22 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Nov 11 1948 and that I last saw h-R alive on Nov 11 1948.

Immediate cause of death	Duration
Coronary Sclerosis due to Arteriosclerosis and Senility	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature Huntington Williams, M. D.
Address 1035 N. Eutaw St. Date signed

VS 150

Fill in all blanks. Print, write the causes of death clearly and legibly.

INSLEY

688822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

688822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 WILLIAM ST.
(c) Hospital or institution:
24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 WILLIAM ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Insley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced.** WIDOWED

6 (b) Name of husband or wife THOMAS H. INSLEY

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN 17, 1888

8. AGE: Years 60 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HENRY L. WICKLEIN
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MR. JOSEPH A. DETTENTALER
(b) Address 3608 WHITE AVE

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 11/24/48 (month, day, year)

(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN, MD.

18 (a) Funeral director JOHN E. DENNY, INC.
(b) Address 715 LIGHT ST. -30

19 (a) NOV 23 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Nov. 1948, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease.

Due to —

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, Jr. M.D.
Medical Examiner.
Date signed 21 Nov. 48

VS 151

92

668823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

668823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr Geo
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Flodeung Chantero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Pr. Geo Co. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Charles Flodeung
13. Birthplace Germany

MOTHER
14. Maiden Name Teresa Bonn
15. Birthplace Germany

16 (a) Informant Helena Chantero
(b) Address Bowie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 46 (month) (day) (year)
(c) Cemetery or crematory Arcenony
Location Bowie Md

18 (a) Funeral director Martin Fleming Funeral Home
(b) Address Bowie Md

19 (a) NOV 22 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946 to Nov 22 1946 and that I last saw h[illegible] alive on Nov 22 1946

Immediate cause of death	Duration
(a) Heart failure	
Due to (b) Old age	
Due to (c)	
Other Conditions Carcinoma of Colon	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 646 W 36th St Date signed 23 Nov 46

VS 150

G68824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68824

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 607 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 16
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 607 Woodington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: EMMA LEE WHEELER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Marean N. Wheeler

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Mar. 12, 1869

8. AGE: Years: 79 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Leesburg, Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Charles O'Conner
13. Birthplace: Va.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. Idelle Taylor
(b) Address: 607 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory: Trinity Chapel
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Timothy Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20, 1948 at 2:29p M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1948 to Nov 20 1948 and that I last saw h[er] alive on Nov 19 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Antecedent
Due to: General Arteriosclerosis
Due to: Arteriosclerosis
Other Conditions: Bronchial Pneumonia — 2 days
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Peter A. Kaplan M.D.
Address: 1219 Dolphin Street Date signed: 11/24/48

VS 150

G68825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 c

Registered No. G68825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Belle Grove Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret McVey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-20-3175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Everett B. McVey
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 10/30/1895

8. AGE: Years	Months	Days	If less than one day
53	0	22	hr. min.

9. Birthplace Wisconsin (Argyle)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cornelius Julius Donahue
13. Birthplace Stockton, Ill.

MOTHER
14. Maiden Name Margaret M. Myers
15. Birthplace Waterford, Ontario, Canada

16 (a) Informant Mr. Everett B. McVey
(b) Address 16 BelleGrove Rd., Catonsville

17 (a) Removal (b) Date thereof 11/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Freeport, Ill.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 23 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/1948, at 2:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948, to 11/22 1948, and that I last saw her alive on 11/22 1948

Immediate cause of death	Duration
Pulmonary congestion & edema	
Due to Rheumatic heart disease with aortic stenosis	yrs?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Rheumatic CVD with aortic stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Kirchner M. D.
Address St. Agnes Hospital Date signed 11/22/48

VS 150

G68826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G68826
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County U.S.A.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Victory Ave, 25
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Chauncey D. Christman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Veda M. Christman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 10-18-1864

8. AGE: Years	Months	Days	If less than one day
84	1	4	hr. min.

9. Birthplace Lykers N. Y.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Milicent K. Christman
(b) Address 922 Victory Ave. Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Cobleskill, N. Y.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Nov 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1948, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-23 1948 and that I last saw him alive on 11-22 1948.

Immediate cause of death Intrahepatic thrombosis - portal vein — Duration 3-5 days
Due to
Due to
Other Conditions old myocardial infarct, pulmonary congestion
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: as given above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lerchen
Address St. Agnes Hospital Date signed 11/22/48 M. D.

VS 159

100 L.

G68827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Auchentoroly Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNIE KATHERINE BLANCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1875

8. AGE: Years	Months	Days	If less than one day
73	1 2	18	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Blanck
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Thies
15. Birthplace Germany

16 (a) Informant Mrs. Arthur H. Miller
(b) Address 3024 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.24.48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves., Balto.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 1:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 13 1948 to Nov 22 1948, and that I last saw h[illegible] alive on Nov 22 1948

Immediate cause of death Carcinomatosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2033 Eutaw Pl. Date signed 11-24-48

VS 150

668828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3918 Cloverhill Rd.
(c) Hospital or institution:
(d) Length. of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Cloverhill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MARGARET KIRBY

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas Milton Kirby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1875

8. AGE: Years	Months	Days	If less than one day
73	1	10	hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Meeth
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schriver
15. Birthplace Germany

16 (a) Informant Mr. T. M. Kirby
(b) Address Briarstone Rd., Randallstown

17 (a) Burial (b) Date thereof 11/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Balto., Md.

19 (a) NOV 23 19[illegible] (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948, at 8:30a M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948, to Nov. 22 1948, and that I last saw h[illegible] alive on Nov. 20 1948

Immediate cause of death: Auricular Fibrillation — Duration: Months

Due to Arterio-Sclerotic Heart disease — years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 325 S. Paca St. Date signed 11/27/48
M D.

VS 150

G68829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Compton St.
(c) Hospital or institution:

24 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Compton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA WALTON

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frank E. Walton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1890

8. AGE: Years 58 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Daniel Anderson
13. Birthplace Balto.

MOTHER
14. Maiden Name Annie McCurley
15. Birthplace Balto. Md.

16 (a) Informant Anna A. Somers
(b) Address 2212 Christian St. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1000 S. Charles St.

NOV 23 1948

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 6 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner
Date signed 11/23/48

VS 181

66880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

66880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Common-Law

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-94

8. AGE: Years	Months	Days	If less than one day
54	8	27	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name	Major Burns
	13. Birthplace	Texas
MOTHER	14. Maiden Name	Louise
	15. Birthplace	Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Bakst. National
Location

18 (a) Funeral director Joseph L. Loeb
(b) Address 1304 N. Central Ave.

19 NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1948 to 11/21 1948 and that I last saw him alive on 11/21 1948

Immediate cause of death Respiratory failure — Duration

Due to Esophagectomy

Due to Carcinoma of esophagus

Other Conditions [redacted]

(Include pregnancy within three months of death)

Date of operation Nov. 20, 1948

Major findings of operation: Carcinoma of esophagus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Leffler, Jr. M.D.
Address Johns Hopkins Hosp. Date signed 11/23/48

VS 150

G688.31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G688.31

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: St. Josephs Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HOWARD SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-1894

8. AGE: Years	Months	Days	If less than one day
54 smt	5	12	hr. min

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Pa.

MOTHER
14. Maiden Name ?
15. Birthplace Pa.

16 (a) Informant Mary Thomas
(b) Address 1015 Ensor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Joseph L. Locke
(b) Address 1304 N. Central Ave

19 (a) NOV 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
~~Cystitis~~
congestive heart failure
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/23/48

VS 151

668832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1210

Registered No. 668832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N Carrollton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Hawkins Watts.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/17/1904

8. AGE: Years 44 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Md Discount Co.

FATHER 12. Name David Hawkins

13. Birthplace Md

MOTHER 14. Maiden Name Frances Thomas

15. Birthplace Md

16 (a) Informant Lilla Taylor (S)

(b) Address 508 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Isaac L Brown & Son

(b) Address 108 W Montgomery St

19 (a) Nov 23 1948 (b) Registered by Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1948 to 11/20 1948.
and that I last saw her alive on 11/20 1948

Immediate cause of death Coronary Thrombosis

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Frankel M D

Address 22 W Lee Date signed 11/22/48

VS 150

668833 CURRY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 668833

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Warner St
(c) Hospital or institution:
21-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife Malachi Curry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	5	-		

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jos Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Harris
15. Birthplace Md

16 (a) Informant Malachi Curry
(b) Address 1138 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Isaac L Bowman Son

18 (a) Funeral director Lowe Monty & Gray Sts
(b) Address

19 (a) Nov 20 1948 (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOVEM 10, 1948 Nov 19 1948. and that I last saw HER alive on Nov 18 1948.

Immediate cause of death Respiratory failure — Duration

Due to arteriosclerotic Cardio vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M.D. M. D.
Address 2010 Monroe St Date signed 11/22/48

VS 150

68834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 68834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Streeper Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Streeper Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Kopper

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George B. Kopper
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Dec. 7th., 1873

8. AGE: Years: 74 | Months: 11 | Days: 14 | If less than one day: ##### min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Herberich
13. Birthplace: Germany

MOTHER
14. Maiden Name: Magda len Schmitt
15 Birthplace: Germany

16 (a) Informant: Mrs. John B. Kopper -- Son
(b) Address: 2011 Sinclair La.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1948, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1946, to 11-21- 1948, and that I last saw h er alive on 11-20-1948.

	Duration
Immediate cause of death: Coronary Thrombosis	Days
Due to: Arteriosel. C. V. disease	2 years
Due to: Arteriosclerosis	
Other Conditions: Diabetes mellitus	5 years

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moore, M. D.
Address 1418 N. Eutaw Ave Date signed 11-22-48 M. D.

937

Please write the causes of death clearly and legibly. Physicians: Please write the causes of death clearly and legibly.

G68835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G688.35

Registered No. 47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Gay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert Pink

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	Not Known

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Margaretha Pink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/15/75

8. AGE: Years	Months	Days	If less than one day
73	7	7	hr. min.

9. Birthplace Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation Business Man
11. Industry or business Wire Cloth Manufacture

FATHER
12. Name Robert Pink
13. Birthplace England

MOTHER
14. Maiden Name Marya Roberts
15. Birthplace England

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Cambridge, Md.
Location

18 (a) Funeral director Kenneth L. Thomas
(b) Address Cambridge, Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13-48 19 , to Nov 23 19 48, and that I last saw him alive on Nov 23, 19 48.

Immediate cause of death Cardiac failure
Due to Bronchopneumonia
Due to Ulceration Larynx
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None to date

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Hunting
Address Church Home Date signed 11 | 23 | 48 (M D)

688.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

688.36
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or ~~Institution~~ St. Joseph's 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 N. Loudon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mullin, James Cornelius

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife. —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 29, 1865

8. AGE: Years	Months	Days	If less than one day: hr.	min.
83	1	22		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John B. Mullin
13. Birthplace ~~Baltimore~~ Ireland

MOTHER
14. Maiden Name Mary E. McAuliffe
15. Birthplace Baltimore

16 (a) Informant Frank Mullin
(b) Address 513 N. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Franklin St.

19 (a) NOV 23 1948 (b) Huntington Williams, Mgr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16, 1948 to Nov. 21, 1948 and that I last saw h im alive on Nov. 21, 1948.

Immediate cause of death	Duration
Hypostatic Pulmonary Congestion.	
Due to Hypertensive Rutevio-	
Due to Sclerotic Heart Disease	

Other Conditions
Epistaxis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature. John T. Everett M. D.
Address St. Joseph's Date signed 11/21/48

VS 150

57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 668837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mayfield & Hilleland Sts
(c) Hospital or institution West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Einar Nees

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 501-01-8123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Jessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1905

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	1	20		

9. Birthplace Oslo Norway (Town, county, and state)
10. Usual Occupation Chef
11. Industry or business

FATHER
12. Name Christen Nees
13. Birthplace Norway

MOTHER
14. Maiden Name Caroline Andersen
15. Birthplace Norway

16 (a) Informant Mrs Jessie Nees
(b) Address 1121 W Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Pellhom & Lee
(b) Address 1217 E Fort Ave

19 NOV 24 1948 (Date rec'd by Registrar) (b) Custis W. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1948 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Nov 1948 to 22 Nov 1948.
and that I last saw him alive on 22 Nov 1948.

Immediate cause of death Bronchio-genic Carcinoma — Duration

Due to Cause unknown.

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Young M. D.
Address U. M. H. Hospital Date signed 24 Nov 48

VS 150

Physicians: please write the causes of death clearly and legibly.

68838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 668838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 W. Barre Street
(c) Hospital or institution:
22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Munzio Prestianni

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 18, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Trackman
11. Industry or business B. & O. R. R. Co.

FATHER
12. Name Munzio Prestianni
13. Birthplace Italy

MOTHER
14. Maiden Name Munzia Russo
15. Birthplace Italy

16 (a) Informant Nancy Yannuzzi
(b) Address 4006 Century Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to Nov 23 1948 and that I last saw h[illegible] alive on Nov 21 1948.

Immediate cause of death Coronary Thrombosis

Due to arter. Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/23/48

VS 153

G688.39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G688.39

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-11-22 13
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th Street. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Fountain Nicholson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Widower

6 (b) Name of husband or wife Eugenia Payne Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June. 30 - 1866

8. AGE: Years	Months	Days	If less than one day
82	4	22	hr. min.

9. Birthplace Caroline Co, Md. (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER
12. Name William G. Nicholson
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret E. Fountain
15. Birthplace Maryland

16 (a) Informant Laura E. Fischer - Night Sup.
(b) Address 700 West - 40th St -

17 Final (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore, Md

18 (a) Funeral director Pulhorn & Son
(b) Address 1219 E. Fort Ave

19 (a) NOV 24 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22. 1948. at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1946. to 11/22 1948. and that I last saw h alive on 19

Immediate cause of death	Duration
Arteriosclerotic Heart Disease.	4 years
Due to Arteriosclerosis (Generalized)	10 years
Due to	
Other Conditions Chronic Bronchitis	30 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergenger M. D.
Address 214 Medical Arts Bldg Date signed 11/23/48

VS 153

6688-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6688-0

BC-48-25490 157 M

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hosp. 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1301 Andre Street (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Boy Reisinger.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11 20 48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William E. Reisinger

13. Birthplace Md.

MOTHER 14. Maiden Name Florence Glenn

15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School NOV 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948 at 8:42 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-21 1948 and that I last saw h alive on 19

Immediate cause of death: Atelectasis of the Newborn — Duration: 1 day

Due to Congenital Atresia, Left Main Bronchus — Duration: 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-20-48

Major findings of operation: Congenital atresia, Left Main Bronchus

of autopsy: Atelectasis, 5 lobes

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward A. Newell M. D.

Address 1213 Light Street Date signed 11-21-48

VS 150

668841

BS-98127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

6688:1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Grindell Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Febee (FEBBER)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
80?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 23 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945 to 11-14 1948 and that I last saw him alive on 11-14 1948

Immediate cause of death: Carcinoma of liver Primary? Le Boudary — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Wilson M. D.
Address BCH Date signed 11-22-48

VS 150

68842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. 68842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Miles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Miles Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Snouffer.

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Widowed.

6 (b) Name of husband or wife Lillie M. Snouffer.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1886

8. AGE: Years	Months	Days	If less than one day
62	1		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Iceman.
11. Industry or business

FATHER 12. Name Richard T. Snouffer.
13. Birthplace Md.

MOTHER 14. Maiden Name Carrie Ginnamon.
15. Birthplace Md.

16 (a) Informant Stanley L. Snouffer.
(b) Address 412 W 29th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 24, 48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's.
Location Hampden.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Cheatnut Ave,

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Nov 22 1948.
and that I last saw h[illegible] alive on Nov 21, 1948.

Immediate cause of death: Carcinoma of Prostate — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature A. Wesley Mc[illegible] M. D.
Address 2902 Huntingdon Ave Date signed 11-23-48

VS 150

668843

BALTIMORE CITY HEALTH DEPARTMENT

668843 Registered No.

B.C.H-00138

CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103-Park Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARFIELD DICKERSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1944

8. AGE: Years	Months	Days	If less than one day
4	11 6	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Otis Dickerson
13. Birthplace S.C.

MOTHER
14. Maiden Name Josephine Wardell
15. Birthplace Va.

16 (a) Informant Josephine Dickerson
(b) Address 425 Heaver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. HALSTEAD
(b) Address 918 Druid Hill Ave.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 15.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 at 7:42 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing X cause of death, fill in the following: 12/5
(a) Date of injury Nov. 20, '48 approx. 7:10 P.M.
(b) Where did injury occur? Greenmount & North Ave.
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? No
(d) Means of injury Ped. struck by auto

23. Signature Medical Examiner. M.D.
Date signed 11/24/48

6688:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6688:4

B- 124606

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2415 Paca St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Laura Brisco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 30- 1880

8. AGE: Years	Months	Days	If less than one day
67	10	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Butler Lambert (D

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Greene (D

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 23 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Entered for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948 at 10.55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11-15- 1948 to 11-16- 1948, and that I last saw her alive on 11-16- 1948

Immediate cause of death: cardiac arrest - hemiplegia ?

Due to: Pneu. Staph. embolus

Due to: Pneu. for. accident

Duration: 2 min

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. F. Nelson M.D.

Address BCH Date signed 11-22-48

VS 150

68845 JL - 124437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

952

Registered No. 68845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 25, 1906

8. AGE: Years	Months	Days	If less than one day
42	4	17	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Belle Watkins
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 23 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) NOV 24 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 5 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948, to Nov. 12 1948, and that I last saw h er alive on Nov. 12 1948

Immediate cause of death	Duration
Uremia	
Due to Other & Rheumatic Heart Disease	
Due to Hypertonic Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address BCH Date signed 11-22

68846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68846 Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 William St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank T. Lindung

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude F. Lindung
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1881

8. AGE: Years	Months	Days	If less than one day
66	11	4	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Police Captain
11. Industry or business Retired

FATHER
12. Name Conrad Lindung
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Matter
15 Birthplace Germany

16 (a) Informant Gertrude F. Lindung
(b) Address 1207 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Cross Cem.
Location

18 (a) Funeral director Elizabeth Hayle Fun.
(b) Address 115 E. West St.

19 (a) NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1948 at 11 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1948 to Nov 22 1948. and that I last saw h[illegible] alive on Nov 22 1948.

Immediate cause of death: Arteriosclerosis Mellitus.
Due to
Due to
Other Conditions: Cerebro sclerosis - Gangrene Lt leg (Include pregnancy within 3 months of death)

Duration

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John A. Schmuck
Address 1357 S. Charles St Date signed 11/23/48

V3 150

68847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 512

Registered No. G68847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 S. Glover Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 S. Glover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. Zielski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-9514

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 2, 1870

8. AGE: Years	Months	Days	If less than one day
78	6	21	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Walenty Zielski
13. Birthplace Poland

MOTHER
14. Maiden Name Marcianna ?
15. Birthplace Poland

16 (a) Informant Mrs Julia Zielski
(b) Address 723 S. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or Holy Rosary
Location Baltimore Co, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 NOV 24 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23rd 1948 at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8th 1948 to Nov. 23 1948, and that I last saw h alive on Nov. 22 1948.

Immediate cause of death: Carcinoma of Prostate metastasis to Pulmonary — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2 yrs ago & 1 yr ago
Major findings of operation Prostatectomy (malignancy) & Pneumonectomy 1 yr ago
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Lyons M. D.
Address 733½ Patterson Pk Pw Date signed 11-23-48

VS 150

G68848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68848

121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT & RUTLAND AVE
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 BRODSHIP RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS SCHULER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	WIDOWED

6 (b) Name of husband or wife MARY SCHULER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) FEB 16, 1865

8. AGE: Years	Months	Days	If less than one day
83	9	7	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business RET. BALTO. TRANSIT

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant MRS. FRED J. THOMAS
(b) Address 19 BRODSHIP RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 26, 1948 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location 7225 EASTERN BLVD.

18 (a) Funeral director Roland L Fuhrman
(b) Address 2112 DUNDALK AVE.

19 NOV 24 1948 (Date filed by Registrar) (b) Tuntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1948, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1948 to 11/23 1948
and that I last saw him alive on 11/23 1948

Immediate cause of death Cardio-Respiratory Failure due to Uremia — Duration 24 Hrs.

Due to Nephrosclerosis & Kidney shut down

Due to

Other Conditions A.S.C.V.D. & coronary insufficiency & arrhythmia
(Include pregnancy within 3 months of death)

Date of operation 11/18/48

Major findings of operation: Gangrene of right leg

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Sussman M.D.
Address Sinai Hospital Date signed 11/23/48

VS 150

668849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

668849

Registered No.

LCH 120143

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1526 Ashland Avenue

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME BEATRICE PUCKETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/12/27

8. AGE: Years	Months	Days	If less than one day
21	9	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wade Puckett

13. Birthplace S. C.

MOTHER

14. Maiden Name Julia Fedd

15. Birthplace S. C.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Anne Arundel County Md

18 (a) Funeral director Mrs Lottie Grant

(b) Address 1408 Ashland ave

19 (a) NOV 24 1948 (Date received by registrar) (b) Huntington Williams, M.D. Address Baltimore City Hosp Date signed 11-23-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 . at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/48 19 . to 11/23/48 19 .

and that I last saw her alive on 11/23/48 19 .

	Duration
Immediate cause of death For advanced bilateral pulmonary tuberculosis	8 months
Due to	
Due to	
Other Conditions Tuberculosis enteritis tuberculosis pleura liver (Include pregnancy within 3 months of death)	3 months

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret A Morgan M D

VS 150

68850

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-25361 CERTIFICATE OF DEATH 159

68850 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts

(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 403 North Mount St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby girl Boozer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/5/48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Charles Boozer

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Martha Roundtree

15. Birthplace Baltimore Maryland

16 (a) Informant Charles Boozer

(b) Address 403 North Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 24, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Joseph A. Pivirotto

(b) Address 640 West Lanvale Street

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-22 1948, and that I last saw her alive on 11-22 1948.

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ann Stevens M.D.

Address University Hospital Date signed 11-23-48

VS 153

G68851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 62B

Registered No. G68851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE ANN TRACY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Noah O. Tracy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1880

8. AGE: Years 68 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William G. Holmes
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Tucker
15. Birthplace Balto., Md.

16 (a) Informant Mr. Noah O. Tracy
(b) Address 224 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 23 1948 and that I last saw h[illegible] alive on Nov 18 1948.

Immediate cause of death: Cardiac failure — Duration: 1947
Due to: Hypertension — 1944
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence M. Lenz M.D.
Address 11 E. Chase St. Date signed 11/25/48

VS 150

6688:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓

6688:52 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Woodington Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. GALE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 14, 1865

8. AGE: Years 83 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Kent Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Saleslady

11. Industry or business

FATHER
12. Name Isaac Gale
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Enos
15. Birthplace Del.

16 (a) Informant Mrs. Thomas W. Gale
(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 8:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1948 to Nov 22 1948 and that I last saw her alive on Nov 22 1948

Immediate cause of death Coronary Occlusion — Duration 4 mos.

Due to

Due to

Other Conditions
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. VonSchultz M.D.
Address 4818 Edmondson Date signed 11/23/48

VE 150

VonSchultz. Ave ×

6688 Hal 7

B.C.H-50196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. 6688:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5427 Tynview Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Wayne Dusich

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-21-46

8. AGE: Years	Months	Days	If less than one day
2	5	2	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation -none

11. Industry or business

FATHER
12. Name Paul Dusich
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mildred McCastle
15. Birthplace Hagerstown, Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23- 1948, at 1:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 1948 to 11-23 1948, and that I last saw him alive on 11-23 1948.

Immediate cause of death: Brain tumor — Duration

Due to: Medulloblastoma of Cerebellum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/20/48

Major findings of operation: Medulloblastoma of Cerebellum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Dieter

Address Johns Hopkins Date signed 11/23/48 M D

VS 153

Maurice P. Dieter X

G688:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 C

Registered No. G688:4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2871 W. Lafayette Ave.
(c) Hospital or institution: H-C

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2871 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CECIL E. BAILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Bailey 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. S. Abell Co.

FATHER
12. Name Benjamin W. Bailey
13. Birthplace Virginia

MOTHER
14. Maiden Name Rose Cherry
15. Birthplace Virginia

16 (a) Informant Mrs. Marie Bailey
(b) Address 2871 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 1:32a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 11/22 1948. and that I last saw him alive on 11/21 1948

Immediate cause of death Carcinoma of the Prostate & generalized Metastases — Duration 20 mos.

Due to

Due to

Other Conditions Hypertensive Cardio Vascular Disease — 4 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. Brafton Hargrove

23. Signature W. Brafton Hargrove M. D.
Address 21 W Mulberry St Date signed 11/24/48

VS 150

G688:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G688:5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 162
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY RAYFIELD ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Seperated from wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1903

8. AGE: Years	Months	Days	If less than one day
44	11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Fruit Handler

11. Industry or business

FATHER
12. Name James Adams
13. Birthplace New Jersey

MOTHER
14. Maiden Name Lillian Adams
15. Birthplace Back River, Md.

16 (a) Informant Edith Truman
(b) Address 1236 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory St Stevens Cem
Location Back River Road Md

18 (a) Funeral director Elwood O. Wilson
(b) Address 1001 Blanton Rd

19 (a) NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 11/22/48

X

G688:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G688:56

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 515 N. Calvert St

(c) Hospital or institution:

5-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 515 N. Calvert St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6-1897

8. AGE: Years 51 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Thomas Price

FATHER 13. Birthplace unknown

MOTHER 14. Maiden Name Annie Howard

MOTHER 15. Birthplace Gloucester Co. Va.

16 (a) Informant Gertrude Brooks

(b) Address 515 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location Brooklyn Md.

18 (a) Funeral director Elroy D. Wilson

(b) Address 1500 Baltimore Ave

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Registrar Walter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st 1948, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948, to Nov. 21 1948, and that I last saw h[illegible] alive on Nov. 21st 1948.

Immediate cause of death: Heart failure — Duration

Due to Pulmonary Edema

Due to Hypertensive C.V.D.

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry A. Price M. D.

Address 118 Biscayne Date signed 11/23/48

VS 150

Harry A. Price

6888.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6888.7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BA RELAY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4923 CEDAR AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES C. BULL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife MARY D. CLARK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 19, 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	3	3		

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation
11. Industry or business B & O. R.R.

FATHER
12. Name ALFRED F. BULL
13. Birthplace MD.

MOTHER
14. Maiden Name ANNIE SIMPSON
15. Birthplace VA.

16 (a) Informant MRS. MARY D. CLARK
(b) Address 4923 CEDAR AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 25 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A. Wright
(b) Address 4101 Edmondson Ave

19 NOV 24 1948 (Date filed by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 22 1948 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 19 48 to 11-22 19 48, and that I last saw him alive on 11-22. 19 48

Immediate cause of death: cardiac failure — Duration:
Due to: acute myocardial infarction
Due to: acute coronary thrombosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury
23. Signature John White M.D.
Address University Hosp. Date signed 11-22-48

VS 150

6688:38

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6688:38

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town rural ~~Big Spring~~ (If outside city or town limits, write RURAL and give town)
(d) Street No. Big Spring (If rural give location)
(e) Citizen of foreign country? N/G (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd Isabelle Jay

3 (b) If veteran, name war

3 (c) Social Security Account No. N G

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1932

8. AGE:

Years	Months	Days	If less than one day
16	4	15	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name William Boyd
13. Birthplace Washington County, Md

MOTHER
14. Maiden Name Ella Bonsi
15. Birthplace Washington Co., Md

16 (a) Informant William Boyd
(b) Address Big Spring Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26, 1948 (month) (day) (year)
(c) Cemetery or crematory St Paul's Cemetery
Location Clear Spring, Maryland

18 (a) Funeral director Snyder-Rowland
(b) Address Clear Spring, Maryland

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~November~~ ~~October~~ 23 1948, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1948 to 11/23/48, and that I last saw h e alive on Oct 23 1948.

Immediate cause of death cardio-respiratory failure

Due to

Due to acute myeloid leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isabelle
Address Univ. Hospital M. D.
Date signed 11/23/48

VS 15)

6688:39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6688:39

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Magothy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

PERSONAL AND STATISTICAL PARTICULARS

FULL NAME Elias (Elijah) Jackson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1861

8. AGE: Years	Months	Days	If less than one day
67 yrs. ?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Beach-Comber
11. Industry or business

FATHER
12. Name Andrew Jackson
13. Birthplace Md ?

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mildred Owens
(b) Address 770 George St (Daughter)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Magothy
Location

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 19 48 to 11-22 19 48 and that I last saw h[illegible] alive on 11-22 19 48

Immediate cause of death	Duration
Respiratory Failure	
Due to Subarachnoid Hem.	
Due to Hypertensive, arteriosclerotic Cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Hahn M. D.
Address University Hospital Date signed 11-22-48

VS 159

68860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68860

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any person who wilfully supplies false information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1717 Eyer St

(c) Hospital or institution:

24

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 Eyer St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jane E. Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Charles F. Buchanan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/8/1858

8. AGE: Years	Months	Days	If less than one day
90	9	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER	12. Name	James Lyons
	13. Birthplace	Ireland
MOTHER	14. Maiden Name	Jane Poins
	15. Birthplace	Chicago

16 (a) Informant Mr John Buchanan

(b) Address 1717 Eyer St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Evergreen Ave

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 1818 Light St

19 (a) NOV 24 1948 (Date received by registrar) (b) Registrar

Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Nov 22 1948. and that I last saw h alive on Nov 22 1948

Immediate cause of death	Duration
Osteosarcoma Myocardium.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. S. H. Garrison

Address 436 E Fortune Date signed 11/24/48 M.D.

668861 ✓ 668861

668861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Front St.
(c) Hospital or institution: 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County /
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Front St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Massimo or Samuel Matricciani

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 220-09-0392

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Teresa Matricciani
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 22 1883

8. AGE: Years	Months	Days	If less than one day
65	1	-	hr. ..... min.

9. Birthplace Atri (Town) Teramo (county) Italy (State)
10. Usual Occupation Forman
11. Industry or business

FATHER
12. Name Francesco Matricciani
13. Birthplace Italy

MOTHER
14. Maiden Name Serafina Lattanzi
15. Birthplace Italy

16 (a) Informant Teresa Matricciani (Wife)
(b) Address 221 N. Front St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

NOV 24 1948 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948 at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1948 to 11/19 1948.
and that I last saw him alive on 11/19 1948.

Immediate cause of death Carcinoma rectum .

Duration .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 7/9/47

Major findings of operation: Carcinoma rectum with generalized metastasis

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature H. J. Bubstaugh M. D.
Address 5 & 2 Belair Rd Date signed 11/24/48

G68862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G68862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabriel F. Schucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie B. Schucker
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 11, 1871

8. AGE: Years	Months	Days	If less than one day
77	8	12	hr. min.

9. Birthplace Clearfield County, Pa. (Town, county, and state)
10. Usual Occupation Retired Construction & Maintenance
11. Industry or business Postal Telegraph

FATHER
12. Name Henry Schucker
13. Birthplace Clearfield County, Pa.

MOTHER
14. Maiden Name Susanne Aurand
15. Birthplace Clearfield County, Pa.

16 (a) Informant Mrs. G. F. Schucker
(b) Address 1101 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Elkridge, Md.

18 (a) Funeral director E. Miller Lamoreaux
(b) Address 4510 Liberty Heights Ave.

NOV 24 1948 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-46 19 to 11-23-48 19 and that I last saw him alive on 11-23-48 19

Immediate cause of death: Myocardial failure — Duration 2 mos
Due to Arteriosclerotic Heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry S Gruber M. D.
Address 1707 Brandon Ave. Date signed 11-23-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Type or print plainly with pen and ink. Do not copy.

668863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

668863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-4620

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Morgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Morgan
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emma Harris
15. Birthplace: Va.

16 (a) Informant: Lucy Morgan
(b) Address: 711 Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Loudon Co. Va.

18 (a) Funeral director Isaac L. Brown Son
(b) Address 1510 Druid Hill Ave

19 (a) Nov 24 1948 (Date received by registrar) (b) Thurlington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at 2.55 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 11-22-48

VS 151

G688b4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

Registered No. G688b4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 74
(e) Length of stay in Baltimore (yrs., mos., or days) 48yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Woodland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Hannie H. Bayly

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 211-03-7235

4. Sex: Female | 5. Color or race: Wh. Fe | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/30/85

8. AGE: Years 62 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace Gettysburg Pa. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

MOTHER / FATHER

12. Name Samuel Russell Bayly

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Margaret Major

15. Birthplace Pennsylvania

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-1948 (month) (day) (year)

(c) Cemetery or crematory Evergreen

Location Gettysburg Pa

18 (a) Funeral director H. Howard Strong

(b) Address 3207 N. North Ave

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948, to Nov 23 1948, and that I last saw him alive on Nov. 23 1948.

	Duration
Immediate cause of death: Generalized Peritonitis	5 days
Anuria	
Due to: Perforation Small Bowel	5 days
Due to:	
Other Conditions: Chronic Duodenal Ulcer	

(Include pregnancy within 3 months of death)

Date of operation 10/27/48; 11/1/48; 11/8/48 + 11/13/48

Major findings of operation: Duodenal Ulcer + Adhesions (Postoperative)

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett

Address Church Home + Hosp Date signed 23 Nov 48

VS 159

X

G68865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68865

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Lake Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis S. Goldbloom (Louis S. Goldbloom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Pearl B. Goldbloom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1876

8. AGE: Years	Months	Days	If less than one day
71	10	29	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Store Prop.
11. Industry or business

FATHER
12. Name Herschel Goldbloom
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Mrs. Herbert Goldbloom
(b) Address 729 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom
Location Balto. Md.

18 (a) Funeral director Blair Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

NOV 24 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 . at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20/48 19 . to 11/23 19 48. and that I last saw him alive on 11/23/48 19

Immediate cause of death Myocardial Infarct — Duration

Due to Coronary art. Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee N. Kastran

Address 300 N. Milton Date signed 11/23/

G68866 **BALTIMORE CITY HEALTH DEPARTMENT**

CERTIFICATE OF DEATH

93

Registration No. 26886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Old York Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Reed Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2449

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	White	Married

6 (b) Name of husband or wife Anna Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58	6	12		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Electrician Inn Office

11. Industry or business

FATHER 12. Name Charles Hall

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Henrietta Mullen

15. Birthplace Germany

16 (a) Informant Anna Hall

(b) Address 4407 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)

(c) Cemetery or crematory Oakdawn

Location Eastern Ave

18 (a) Funeral director John C Moran

(b) Address 3060 E Baltimore St

NOV 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1948 at 4:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948 to Nov. 22 1948, and that I last saw him alive on Nov. 22 1948.

Immediate cause of death	Duration
Pulmonary Edema	1 hrs.
Due to Chronic Myocarditis	Yrs
Due to	
Other Conditions Hypertension	Yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Mebob M.D.

Address 6014 York Road Date signed 11-23-48.

VS 150

66887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66887

66887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Indans Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Mulberry Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Tomlinson Tumbleson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Thomas Tumbleson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 31, 1889

8. AGE: Years 58 Months 59 Days 10 If less than one day hr. 23 min.

9. Birthplace Maryland, Balto.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Thomas Hogan
13. Birthplace New York

MOTHER
14. Maiden Name Rose Ann Heiring
15. Birthplace Cambridge Md.

16 (a) Informant Mrs Mary Smith
(b) Address 212 Mulberry Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1948, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1948 to 11-23 1948, and that I last saw h[illegible] alive on 11-23 1948.

Immediate cause of death: Subarachnoid hemorrhage — Duration 6 hrs.

Due to: Hypertension CVD — Duration 2.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Jr. M. D.

Address Mercy Hosp Date signed 11-23-48

VS 150

G688o8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G688o8
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 Hollins St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Hollins St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Antonas Lauciatis (Lauciates).

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 217-03-5433

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anna.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) Feb-11-1889

8. AGE: Years 59 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Lithuania (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Baltimore Coat makers

FATHER
12. Name Jolyn
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Anna Lauciatis
(b) Address 828 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month, day, year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W Fackenthal
(b) Address 703 McHenry St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

NOV 24 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-48 19 . at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 19 . to 11-22-48 19 , and that I last saw h/m alive on 11-22-48 .

Immediate cause of death Terminal Bronchopneumonia bil. Duration 1 D.

Due to General Arteriosclerosis

Due to Cerebral Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O. Lange M. D.
Address 642 N. Gay St. Date signed 11-24-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68869 ✓ G68869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Charter Oak Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY OSBORNE MURROW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Shubal E. Murrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	26	hr. min

9. Birthplace Greensboro, N.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Daniel Osborne
13. Birthplace North Carolina

MOTHER
14. Maiden Name Adele Stevens
15. Birthplace North Carolina

16 (a) Informant Mrs. John Pilling (Daughter)
(b) Address Be 4275 3391 Winston Ave.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** Nov 24, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Greensboro N. C.

18 (a) Funeral director Henry W. Jenkins & Sons Co.
(b) Address 4905 York Rd. Huntington Williams, Md.

19 (a) 1948 (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at 5.50a. M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Traumatic pneumothorax left

Due to Fracture of Ribs left

Other Conditions Rupture of spleen

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27/10

(a) Date of injury 11-13-48 at approx. 11.45 a. M.
(b) Where did injury occur? York Rd. & Richwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed November 23, 1948

CERTIFICATE CORRECTED 9-1-50

68870 BALTIMORE CITY HEALTH DEPARTMENT 68870

Registered No.

CERTIFICATE OF DEATH 133a

LCH - 123629

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month & 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 27 N. Carey Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME IDA GETTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1880 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leroy Getts

13. Birthplace Pa.

MOTHER 14. Maiden Name Kathryn Bobendorf

15. Birthplace Pa.

16 (a) Informant B.C.H. records

(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)

(c) Cemetery or crematory Forest Hill

Location Timmons, Pa.

18 (a) Funeral director Wm Cook Jr.

(b) Address 1217 St Paul St.

19 (a) 1948 (b) Rec'd by registrar Registrar

24 1948 Huntingdon Williamsburg, Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/48 19 at 2:30 AM. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/48 19 to 11/24/48 19 and that I last saw him or her alive on 11/24/48 19

Immediate cause of death Bronchopneumonia — Duration 2 days.

Due to

Due to

Other Conditions pyelonephritis with uremia. — 2 weeks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E. Bechtold M. D.

Address Balto City Hosp. Date signed 11-27-48

107

G68871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G68871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Magrogan

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: ?

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John G. Magrogan
6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1912

8. AGE: Years: 35 | Months: II | Days: 20 | If less than one day: ########## min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: James M. O'Connor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Roche
15. Birthplace: Ireland

16 (a) Informant: Mr. John G. Magrogan
(b) Address: 1632 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: II/26/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cemetery
Location: Edmondson Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Nov 24 1948 (b)
Registrar: Washington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1948 at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~June~~ 1947 to Nov 22 1948.
and that I last saw ~~him~~ alive on Nov 22 1948.

Immediate cause of death: Carcinoma of left breast — Duration: 2 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: June 22, 47.
Major findings of operation: Carcinoma of left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: W. H. Brengar M. D.
Address: 1402 E. Lanvale St. Date signed: 11 23 48

V S 150

Dr. Feinglas 68872 BALTIMORE CITY HEALTH DEPARTMENT
2002 E. Pratt St CERTIFICATE OF DEATH 927

Registered No. 68872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Foster Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Foster avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) if yes, name country

3 (a) **FULL NAME** Rosalia Sidlak Also spelled Siedlok, Seidlo and Sidlock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1871

8. AGE: Years	Months	Days	If less than one day
77	6	12	hr. min

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Fisher
13. Birthplace Poland

MOTHER
14. Maiden Name Lena
15. Birthplace Poland

16 (a) Informant Mrs. Theresa Tessler
(b) Address 614 S. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1948 at 5:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 4 1948 to Nov 24 1948, and that I last saw her alive on Nov 23 1948.

Immediate cause of death: Acute Cardio-Vascular decompensation
Due to: Thrombo-Arteritis Endocarditis Chr. Arteriosclerosis
Due to:
Other Conditions C.P.C. Lungs
(Include pregnancy within 3 months of death)

Duration: acute ?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil Feinglas M. D.
Address 700 N. Patterson Park Date signed 11/27/48

G68873 ✓ G68873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Rosebank Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Bayne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Katherine Frazier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1870

8. AGE: Years	Months	Days	If less than one day
78	1	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation clerk
11. Industry or business McPherson's Men's Furnish.

FATHER
12. Name Benjamin C. Bayne
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Frances Carey
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. G. Parker McPherson
(b) Address 3333 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1948 (Date rec'd by registrar) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 Hours ~~1948~~ and that I last saw h alive on Hours 1948

Immediate cause of death	Duration
Coronary Occlusion	Months
Due to Arteriosclerotic condition	1 yr
Due to Cerebral accident	1 yr ago
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation no
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Keyser M. D.
Address Wentworth Arms Apts. Date signed Nov 24 48

VS 180

G68874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68874
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Dixie Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Cockey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Grace Rowe
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) Dec 15 1873

8. AGE: Years 75 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business Retired

FATHER
12. Name John Cockey
13. Birthplace Baltimore County Md

MOTHER
14. Maiden Name Anna Hutchins
15. Birthplace Maryland

16 (a) Informant Mrs. Grace R. Cockey
(b) Address 2 Dixie Drive Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory St. James Cemy.
Location The Manor, Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948, at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1948, to 11/24 1948, and that I last saw him alive on 11/24 1948.

Immediate cause of death	Duration
Cardiac failure - Arteriosclerosis	
Due to Accidental Intracranial hemorrhage	
Due to Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Montes
Address Church Home Date signed 11/24/48 M. D.

VS 151

G68875 ✓ G68875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No.

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Eutaw Place
(c) Hospital or institution: none 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma V. Jones Stoddard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife J. William Stoddard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) February 23, 1867

8. AGE: Years	Months	Days	If less than one day
81	9	---	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alexander Jones
13. Birthplace St. Mary's County, Md.

MOTHER
14. Maiden Name Isabella C. Shaw
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anita Johnston
(b) Address 1639 Gwynns Falls Parkway

17 (a) Burial (b) Date thereof 11/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore

19 (a) NOV 24 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 at 5 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1948, to Nov 23 1948, and that I last saw h[illegible] alive on Nov. 22 1948.

Immediate cause of death — Myocardial Infarction;

Duration Fatal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Preston, M. D.
Address 1403 Park Avenue Date signed Nov 24 48

68876 JL- 122915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 R

Registered No. 68876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Henryton Sanitorium
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Moses Goldring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years	Months	Days	If less than one day
35 ?			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Grant Goldring
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-48 (month) (day) (year)
(c) Cemetery or crematory
Location Leonardtown, St Marys Co. Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, St. Mary's Co., Md.

19 NOV 25 1948 Huntington Williams, M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 8.45 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948 to Nov. 13 1948, and that I last saw him alive on Nov. 23 1948.

Immediate cause of death Respiratory failure — Duration

Due to Cachexia & Pulmonary tuberculosis with empyema

Due to

Other Conditions Dehydration, de hydration

(Include pregnancy within 3 months of death)

Date of operation 9/25/48, 11/16/48

Major findings of operation: Pulmonary tuberculosis

of autopsy: Cachexia.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Mundy M.D.
Address Balto. City Hosp. Date signed 11/24/48

VS 150

G68877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G68877
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4447 Belair Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Merz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James Conrad Merz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1888

8. AGE: Years 59 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Hwfe.

11. Industry or business

FATHER
12. Name Frank Gruel
13. Birthplace Austria

MOTHER
14. Maiden Name Julia Simard
15. Birthplace Austria

16 (a) Informant Mr James Merz
(b) Address 4447 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Joa J Henderson
(b) Address 3001 Huntingdon Ave

19 NOV 25 1948 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1948. at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/ 1948. to 11/23/ 1948.
and that I last saw her alive on 11/23/ 1948.

Immediate cause of death Uremia — Duration

Due to Chronic Nephritis

Due to

Other Conditions Diabetes Mellitus

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Guy E Thompson Jr. M.D.
Address St Joseph's Hosp Date signed 11/23/48

12/12

VS 150

68878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 68878

Please print plainly, write with pen and use only black or blue ink. Report one cause on a line. Do not use abbreviations. If none, write NONE. If unknown, state so. Do not leave blanks. Be sure to fill in items 22 and 23 on reverse side. Underline the cause to which death should be charged statistically. Sign certificate as soon as possible after death. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4613 Park Heights Ave

(c) Hospital or institution: -7-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4613 ParkHeights Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Dora Millman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant David A Millman

(b) Address 2228 Ruskin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25, 1948 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem

Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 NOV 25 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948 12.25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1948 to 11/22 1948 and that I last saw h alive on 11/22 1948

Immediate cause of death	Duration
Gangrene Left Leg.	
Due to Infarction	
Due to Carcinoma of Liver	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. H. Hornstein M. D.

Address 204 E. Biddle St Date signed 11/25/48

VS 150

068879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 068879

469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 318 days
(e) Length of stay in Baltimore (yrs., mos., or days) 318 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town CATONSVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 FREDERICK ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME OSCAR Bechtol Coblentz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215-09-5066

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Margaret Pontius Coblentz
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1878

8. AGE: Years 69 | Months 11 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Middletown, Maryland (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business McLean-Combaugh Co

FATHER
12. Name Edward L. Coblentz
13. Birthplace Middletown, Maryland

MOTHER
14. Maiden Name Lucinda F. Bechtol
15 Birthplace Middletown, Maryland

16 (a) Informant Union Memorial Hosp. Records
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Reformed Lutheran Cemetery
Location Middletown - Md.

18 (a) Funeral director Shiverts Mortuary
(b) Address 1919 W. North Ave. Baltimore, Md.

19 NOV 25 1948 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 10, 1948 to Nov 22 1948, and that I last saw him alive on Nov. 22, 1948.

	Duration
Immediate cause of death: Carcinoma of Pancreas with metastasis to liver and retroperitoneal	
Due to lymph nodes.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov. 11, 1948

Major findings of operation: Umbilical hernia, Ascites, indurated pancreas, enlarged nodes

Findings of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature J. Frank Supplee III, M.D.
Address Union Memorial Hosp. Date signed 11/22/48

VS 150

668880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

668880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4023 Wilkens Ave.
(c) Hospital or institution: 25-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Dein (Diem)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife John Diem

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1868

8. AGE: Years 80 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER 12. Name John Zill

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth ?

15. Birthplace Germany

16 (a) Informant George Tuhpannecker

(b) Address 202 S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Ave.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to Nov 25 1948, and that I last saw her alive on Nov 18 1948

Immediate cause of death: Arteriosclerotic Heart disease with failure — Duration: 4 yrs.

Due to Generalized Arteriosclerosis — 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Fass, M.D.

Address 4007 Wilkens Ave Date signed 11-25-48 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Ulman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Goldman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER 12. Name: Aymaye
13. Birthplace: Russia

MOTHER 14. Maiden Name: Rachael
15. Birthplace: Russia

16 (a) Informant: Mary Garnett
(b) Address: 3572 White Chapel Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2600 Eutaw Place

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24- 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1947, to 11/24 1948.
and that I last saw him alive on 11/24 1948.

Immediate cause of death: Acute cerebral Hemorrhage — Duration

Due to: ch arteriosclerosis

Due to: ch Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. H. Hornstein
Address 204 E. Biddle St Date signed 11/24/48

VS 150

Please write the entries on this certificate clearly and legibly.

68882 B.C. 48-28902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 M

V 68882 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5000 Elmer Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY GIRL SHULMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 11/23/48

8. AGE: Years | Months: 1 | Days | If less than one day: hr min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Manuel Shulman

13. Birthplace Poland

MOTHER 14. Maiden Name Esther Rosenzweig

15. Birthplace Poland

16 (a) Informant Manuel Shulman

(b) Address 5000 Elmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location Jack Keiffer Drive

18 (a) Funeral director Levine

(b) Address 2100 Eastern Place

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23, 1948 at 10:03 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/23 1948 to 11/23 1948 and that I last saw her alive on 11/23 1948.

Immediate cause of death	Duration
Osteogenesis Imperfecta Congenita with Fractured L Bad Femora & Bad Humeri	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Allan Y. Wolinsky M.D.

Address Sinai Hosp Date signed 11/24/48

VS 150

68883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 68883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Hortonia Rd
(c) Hospital or institution: The Mount Hope Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1701 No Fenteton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pete Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Meryam
15. Birthplace Russia

16 (a) Informant Fannie Shapiro
(b) Address 1701 No Fenteton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phelps Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) NOV 25 1945 (Date rec'd by registrar) Huntington Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945 at 7:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 46 to Nov. 24 1945 and that I last saw him alive on Nov. 44 1945

Immediate cause of death Myocarditis with fatal heart block.

Due to

Due to

Other Conditions Hypertension & paralysis
(Include treatment within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro
Address 2028 Eutaw Place Date signed 11-26-45

VS 150

168884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. 168884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Arlington Nursing Home
(c) Hospital or institution:
3520 Liberty Rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Gilmanton Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Jennie May Preston

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1882

8. AGE: Years	Months	Days	If less than one day
66	6	0	hr. min.

9. Birthplace Hartford Co Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Robert Preston
13. Birthplace Hartford Co Md

MOTHER
14. Maiden Name Anna Gerhardt
15. Birthplace Baltimore Md

16. (a) Informant Mrs Edna Donnelly
(b) Address Gilmanton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1948 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Gilmanton Md

18 (a) Funeral director Henry Tawney Hood
(b) Address Gilmanton Md

19 (a) [illegible] 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1948, at 4:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948, to Nov 25 1948, and that I last saw h[illegible] alive on Nov 24 1948.

Immediate cause of death	Duration
Carcinoma Stomach	1 mo
Due to wall (Mo)	
Due to	
Other Conditions Emaciation Arteriosclerosis	1 mo

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. H. D. Stevens M. D.
Address 2818 Hartford Ave Date signed 11 25 48

V S 150

668885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

Registered No. 668885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Street
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Route #5
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #5
(If rural, give location)
(e) Citizen of foreign country? Ono (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Sauat

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 1948

8. AGE: Years | Months 10 | Days | If less than one day hr. min.

9. Birthplace Westminster, Carroll, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Kenneth Sauat
13. Birthplace Md.

MOTHER
14. Maiden Name Elsie Fritz
15. Birthplace Md.

16 (a) Informant father
(b) Address Route #5 Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cemetary
Location Union Bridge, Md.

18 (a) Funeral director C. O. Fairbrother & Sons.
(b) Address Union Bridge & Westminster

19 (a) (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1948, to Nov. 25 1948, and that I last saw him alive on Nov. 25 1948.

Immediate cause of death	Duration
~~Acute pneumonia terminating~~ Acute respiratory failure	
Due to Acute laryngo-tracheo-bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/24/48

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Tremblay Jr.
Address University Hosp. Date signed 11/26/48 M D

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G68886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS ZINKAND

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Zinkand

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr) Oct. 15, 1869.

8. AGE: Years 79 | Months 1 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business Baltimore City Worker.

FATHER
12. Name Nicholas Zinkand
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ann Hartmann
15. Birthplace Germany

16 (a) Informant Rosa Zinkand (Widow)
(b) Address 3800 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles S. Feiler.
(b) Address 901 S. Conkling St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1943 to Nov 23 1948, and that I last saw h alive on Nov 22 1948.

Immediate cause of death: Arteriosclerosis — Duration: 1943

Due to: Hypertensive Heart Disease — Nov 20 — 1948

Due to:

Other Conditions:
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Huntington M D
Address 3424 Bank St. Date signed Nov 24 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668837

829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 413 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES HEYWARD TAYLOR

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 25, 1880

8. AGE: Years 68 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Self

FATHER
12. Name Winfield Taylor
13. Birthplace

MOTHER
14. Maiden Name Decima Heyward
15. Birthplace

16 (a) Informant Decema S. Heyward
(b) Address 662 Register Ave.,

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/27/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Waverly, Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 25 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1948, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15th 1948, to Nov. 24th 1948, and that I last saw h in alive on Nov. 24th 1948.

Immediate cause of death
Cerebral Hemorrhage — Duration 1 day
Due to Arterio-Sclerosis — 2 days
Due to — Long
Other Conditions Pernicious anaemia — Long
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Jos Blalock, M.D.
Address 1200 N. Calvert St Date signed Nov. 24/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No. 668838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AMELIA RITTLE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): March 1889
8. AGE: Years 59 | Months 8 | Days | If less than one day hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Joseph Rittle
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: David G. Weiland
(b) Address: 2559 Kirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory: Schwartz
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (Date rec'd by Registrar) NOV 25 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 19 48 to 11/24/48 19 , and that I last saw h alive on 11/24/48 19 .

Immediate cause of death: Myocardial Renal — Duration: unknown

Due to: Cancer Stomach — Duration: unknown

Due to: Diabetes — Duration: "

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm F Corrin, M.D.
Address 1012 Eastern Ave. Date signed 11/29/48

VS 150

68889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

Registered No. 68889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 West 34th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Tudor Arms Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME KATHERINE F. STEIGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1859

8. AGE: Years	Months	Days	If less than one day
89	6	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Schoolteacher, retired
11. Industry or business

FATHER
12. Name Joseph Steiger
13. Birthplace

MOTHER
14. Maiden Name Elizabeth French
15. Birthplace Md

16 (a) Informant Mrs Clarence Boggs,
(b) Address 3705 Beech Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 , at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 19 48 to Nov 24 19 48 and that I last saw h[illegible] alive on Nov 23 19 48.

Immediate cause of death Myocarditis — Duration 1 mo.
Due to Arterio Sclerosis — Duration 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed Nov 24/48

8890 BC-48-25300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65350

160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3rd South Balt General
(c) Hospital or institution: 1213 Light Street Balt Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Shortway Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley D. Lurz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 20-48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter B. Lurz
13. Birthplace Balto Md

MOTHER 14. Maiden Name Ida Unthank
15. Birthplace Ky

16 (a) Informant Walter B. Lurz
(b) Address 3117 Shortway. Dundalk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location Towson Balto Co

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948, at 11 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/20 1948 to 11/24 1948, and that I last saw h[illegible] alive on 11/24 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopay:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/25/48

VS 150

68891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. 68891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33 E CALVERT ST.
(b) Street address ~~UNION MEMORIAL HOSPITAL~~
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 22d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 22d.

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town CHARLESTON (If outside city or town limits, write RURAL and give town)
(d) Street No. FRANCIS MARION HOTEL (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT T. ROSEMOND.

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M Rosemond

6 (b) Name of husband or wife LOUISE BRADSHAW
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 23 1878

8. AGE: Years	Months	Days	If less than one day
70	5	2	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation HOTEL MANAGER.
11. Industry or business

FATHER
12. Name HENRY ROSEMOND
13. Birthplace N.C.

MOTHER
14. Maiden Name DORA PALMER [redacted]
15 Birthplace N.C.

16 (a) Informant Mrs Louise B. Rosemond
(b) Address Belvedere Hotel

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Greenhill Cem
Location Greensboro N.C.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) [illegible] Williamsburg, Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25- 19 48, at 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 3 19 48 to NOV 25 19 48, and that I last saw h[illegible] alive on NOV 25 19 48.

Immediate cause of death Ca of stomach — **Duration**

Due to

Due to

Other Conditions Generalized

(Include pregnancy within 3 months of death)

Date of operation 9-29-48

Major findings of operation: Ca of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [signature] M.D.
Address [illegible] Date signed 11-[illegible]

X

VS 150

68892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. 68892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 3'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB George MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Phila Pa (Town, county, and state)

10. Usual Occupation Shipper

11. Industry or business

FATHER
12. Name Lemon
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Gertrude Miller
(b) Address 325 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Nevgrn Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

NOV 25 1948 (b) Huntington Ave Baltimore Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948 at 10 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1 1948 to 11/24 1948 and that I last saw him alive on 11/24 1948.

Immediate cause of death Uremia
Pulmonary Edema
Pulmonary Infarction
Due to Rheumatic Heart Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Jaffe MD
Address Sinai Hospital Date signed 11/25/48

VS 150

68893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 668893

Please write clearly with pen or pencil. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 N. Montford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Christian W. Daub

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6092

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophie Daub
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12-1877

8. AGE: Years	Months	Days	If less than one day
71	7	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Leverson + Klein

FATHER
12. Name Ludwig Daub
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kraty
15. Birthplace Balto. Md.

16 (a) Informant Sophie Daub
(b) Address 716 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem. Co.
Location North Ave + Gay St.

18 (a) Funeral director John C. Miller
(b) Address 2334 Jefferson St.

NOV 25 1948 (Date rec'd by registrar) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 3 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1941, to Nov. 23 1948, and that I last saw him alive on Nov. 23 1948.

Immediate cause of death Cerebral Thrombosis — Duration 5 days
Due to Cerebral Arteriosclerosis
Due to Cerebral Arteriosclerosis
Other Conditions Hypertensive Heart Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick Tooke M.D.
Address 845 N. Patterson Pk. Date signed 11/24/48

832

BC-C-6153 ✓ 6688-14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Linden Ave
(c) Hospital or institution: 1st floor front

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Linden Ave 1st Floor front
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Anne Banks ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1944

8. AGE: Years 3 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Banks
13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Lee Spence
15. Birthplace Richmond County Va

16 (a) Informant Mary Lee Banks
(b) Address 1013 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory W. F. Calvary Cemetery
Location Cedar Hill Ave. Catonsville

18 (a) Funeral director Harry Halstead
(b) Address 918 Washington Blvd

19 NOV 25 1948 (Date received by Registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23-1948 to 11-25-1948 and that I last saw her alive on 11-23-1948.

Immediate cause of death Pulmonary Congestion — Duration —
Due to Bilateral Lobar Pneumonia — Duration 24 hrs.
Due to — Duration —
Other Conditions None — Duration —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1723 Druid Hill Ave Date signed 11-23-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 68895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 E Pratt (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ULYSSES STANLEY KNOCHEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Beulah Knochel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1889

8. AGE: Years	Months	Days	If less than one day
59	5	12	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business Md Dry Dock

FATHER
12. Name Conrad Knochel
13. Birthplace Ger

MOTHER
14. Maiden Name Margaret Gerkensing
15. Birthplace Ger

16 (a) Informant Mrs Beulah Knochel
(b) Address 3708 E Pratt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1948 to 11-23 1948 and that I last saw h alive on 11-23 1948

Immediate cause of death (a) Coronary Occlusion

Duration

Due to Myocardial infarct

Due to Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Alfred Gerkensmeier M.D.
Address University Hosp Date signed 11-23-48

VS 150

Please write the causes of death clearly and legibly. Physicians: please write plainly; important.

16896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 16896

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Kimble Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Kimble Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha A Tippett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24 1873

8. AGE: Years 75 | Months 7 | Days 29 | If less than one day hr. min

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Robert Tippett
13. Birthplace Eng

MOTHER
14. Maiden Name Mary Williams
15. Birthplace Wales

16 (a) Informant Mrs Carrie Linenmayer
(b) Address 3607 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wellwood Funeral Home
(b) Address 2008 Orleans

19 (a) (Date received by registrar) NOV 25 1948 (b) Burlington for Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1948 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 to Nov 23 1948
and that I last saw h[illegible] alive on 11-29-48

Immediate cause of death Hypertensive Cardiovascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 17

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Burgdorf M. D.
Address Date signed 11-24-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

688897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 688897

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Baltimore Sts.
(c) Hospital or institution:
Hotel Emerson

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore & Calvert Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GOLDSMITH

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Hattie V. Goldsmith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1870

8. AGE: Years 78 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Goldsmith
13. Birthplace Europe

MOTHER
14. Maiden Name Yetta ?
15. Birthplace Europe

16 (a) Informant Mrs. Hattie V. Goldsmith
(b) Address Hotel Emerson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 10:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 18 1948 to Nov 23 1948 and that I last saw him alive on Nov. 23 1948

Immediate cause of death: Arteriosclerosis, cerebral — Duration: 6 mos.

Due to

Due to

Other Conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Z. Rhinefeldt M.D.
Address 1101 St. Paul St. Date signed Nov. 26, 48

VS 1/50

97

68898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 423 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA VIRGINIA PRESTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	29	Hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Robert A. Preston
13. Birthplace Harford Co.

MOTHER
14. Maiden Name Sarah F. Rolls
15. Birthplace Harford Co.

16 (a) Informant Miss Flora E. Preston
(b) Address 248 W. Phila. St., York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

NOV 29 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 7:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21, 1948 to Nov 23 1948, and that I last saw her alive on Nov 23 1948

Immediate cause of death	Duration
Right hemiplegia	
Due to Hypertension	
Due to	
Other Conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hope E. Gammon M.D.
Address 520 Medical Arts Bldg Date signed Nov 24, 48

VS :50

68899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 68899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 E. 30th. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 E. 30th. Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME EMMA LAVINIA COOPER (COOPER)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Carroll Cooper

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1877

8. AGE: Years 71 | Months 0 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Thomas Hammen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Angenora Hughes
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles C. Cooper
(b) Address 1737 E. 30th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 19 48 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 48 to N-25 19 48
and that I last saw her alive on N-23 19 48

Immediate cause of death
INTESTINAL OBSTRUCTION — Duration 3 Mos
Due to CANCER PANCREAS — 1 Yr
Due to
Other Conditions THYROID ADENOMA
(Include pregnancy within 3 months of death)
Major findings: Of operations CA PANCREAS
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Kurtz M. D.
Address 4331 Hayford Pl. Date signed N-24-48

VS 3

68900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. 68900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Georgetown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Georgetown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10-1875

8. AGE: Years	Months	Days	If less than one day
73	8	14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Pastry Bakery

FATHER
12. Name William H. Perry
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Ash
15. Birthplace Baltimore Md

16 (a) Informant Mary Francis Perry
(b) Address 2821 Georgetown Rd

17 (a) Burial (b) Date thereof Nov 27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Rd

18 (a) Funeral director Walter J. Schweinburg
(b) Address 1126 W. Cross St.

19 NOV 25 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1948 to 11-24 1948 and that I last saw h alive on 11-24 1948

Immediate cause of death Acute Heart failure — Duration 1 day

Due to Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1948

Major findings of operation: Carcinoma of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klein M.D.

Address 876 Underwood Date signed X 11/24/48

VS 150

68901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Sarahann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Sarahann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAUDE FLOYD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/8/1882

8. AGE: Years	Months	Days	If less than one day
66	1	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Junk Dealer
11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Sarah Thorton (Friend)
(b) Address 1115 Sarahann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 25 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 6:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 11/23 1948, and that I last saw him alive on 11/23 1948.

Immediate cause of death Cerebral vascular accident (Hemorrhage) — Duration 5 days
Due to
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Garner
Address 253 Conway Date signed 11/27/48

X

68902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinia Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 6
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3805 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Edward Twele

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lydia Twele

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): 1903

8. AGE: Years: 45 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Police Sgt.

11. Industry or business: (retired)

FATHER
12. Name: Frederick Twele
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary A Flaherty
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Edward Twele
(b) Address: 3805 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: WIEDEFELD & SON
(b) Address: GREENMOUNT AVE & 22ND

19. NOV 25 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 19 48 at 6 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 19 48 to 11/23 19 48, and that I last saw h[illegible] alive on 11/23 19 48

Immediate cause of death	Duration
A Hemorrhage Brain HT disease and coronary occlusion	
Due to & pulmonary edema	
Due to	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature [signature] M D
Address [illegible] Hosp. Date signed 11/23/48

VS 193

BC-48-2514

68903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 68903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city limits or town write RURAL and give town)
(d) Street No. 2 Orchard Drive Ellicott City (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lawson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 18, 1948

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Victor R. Lawson
13. Birthplace Md.

MOTHER
14. Maiden Name Ruby L. Hunter
15. Birthplace Md.

16 (a) Informant Hospital Records.
(b) Address St Agnes - Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director J. C. Hyneholdaw
(b) Address Ellicott City Md.

19 (a) NOV 25 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/48 19 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18/48 19 to 11-25 19 48 and that I last saw h alive on 11-25 19 48

Immediate cause of death: Prematurity 32 wks

Due to: Cardio Resp failure

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence A. O'Leia Jr. M.D.
Address St Agnes Hosp Date signed 11/26/48

VS 150

668904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 194 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, Hermie Hartfield

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife French Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1893

8. AGE	Years	Months	Days	If less than one day
	54	8	7	25 hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Howard Hartfield

13. Birthplace Benson, N. C.

MOTHER 14. Maiden Name Lucinda Streeter

15. Birthplace N. C.

16 (a) Informant French Williams.

(b) Address 324 East Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1948 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) Nov 25 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1948 to 11/23 1948, and that I last saw her alive on 11/23 1948.

Immediate cause of death	Duration
Secondary Shock	
Due to Cellulitis of Lumbar region	
Due to Diabetes Mellitus	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Marcus W. Moore Sr

Address Provident Hospital Date signed 11/25/48

VS 150

668905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Washington Blvd (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Frank Martindale

3 (b) If veteran, name war none

3 (c) Social Security Account No. 217-12-5058

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Martindale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1875

8. AGE: Years 73 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Wood Workers

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Harriet ?
15. Birthplace ?

16 (a) Informant Lena Martindale
(b) Address 2302 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Co Md

18 (a) Funeral director Edward Poulson
(b) Address 2359 Washington Blvd

19 (a) Date rec'd 1948 (b) Huntington Williams M.D. (Registrar)
NOV 25 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to Nov. 25 1948, and that I last saw h[illegible] alive on Nov. 25 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic C-V-D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Clifton Rosenplatt M. D.
Address 2411 Wash. Blvd. Date signed 11/25/48

X

Type or print plainly with pen or pencil. If physician, please write the causes of death clearly and legibly.

G68906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw St
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Gulgrove Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard M. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Bertha Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21, 1868

8. AGE: Years 79 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county or state)

10. Usual Occupation Retired Plumber

11. Industry or business

FATHER
12. Name Stephen Miller
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary J. Friedhofer
15. Birthplace Md

16 (a) Informant John L. Miller
(b) Address 2306 Gulgrove Rode

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Edward Tawson
(b) Address 2359 Washington Blvd (Funeral director or Williams, M...)

19 (a) NOV 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1948. to Nov. 23 1948. and that I last saw h— alive on Nov. 23 - 1948.

Immediate cause of death Generalized carcinomatosis — Duration

Due to Ca - Lower colon

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Faccl M. D.
Address 1700 Eutaw Pl. Date signed 11-26-48

VS 150

G68907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G68907
Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) **FULL NAME** Frank Leo

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-9245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife Maria Santa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1871

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Leo
13. Birthplace Italy

MOTHER
14. Maiden Name Angela Pama
15. Birthplace Italy

16 (a) Informant Angeline Leo
(b) Address 1117 Poplar Grove Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-27-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Zarace Inc.
(b) Address 2[illegible] Greenmount Ave

19 (a) NOV 25 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 at 4 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7, 1948 to Nov. 24, 1948, and that I last saw h alive on Nov. 24, 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular disease with Cardiac Hypertrophy & Diabetis	3 mo.
Due to	
Due to	
Other Conditions Diabetis Mellitus	12 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Tenniell.
Address Medical Asst. Bldg. Date signed 11/24/48 M.D.

VS 150

GB9088 B.C. # 28910 Hospital Dispo 7-2-92

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. GB9088

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kenneth Taylor

13. Birthplace ? ?

MOTHER 14. Maiden Name ? ?

15. Birthplace ? ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) NOV 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948 at 1:25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Congenital atelectasis	
Due to	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. C. Ravin M. D.

Address Johns Hopkins Hosp Date signed 11-15-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

G68903 BC-48-25499 CERTIFICATE OF DEATH 161a

Registered No. G68903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27 + 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5803 Chinquapin Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dunphy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 16-1918

8. AGE: Years	Months	Days	If less than one day
—	—	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Charles H. DUNPhy
13. Birthplace

MOTHER
14. Maiden Name Shirley Gill
15 Birthplace

16 (a) Informant U. mem. Records
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Disposed of by Hospital.

18 (a) Funeral director
(b) Address

19 (a) NOV 25 1918 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1918, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from November 19 19 18 to November 19 19 18, and that I last saw h[illegible] alive on November 19 19 18

Immediate cause of death Anoxia

Due to: massive atelectasis

Due to Congenital state

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: massive atelectasis

Duration: 4 days (present since birth)

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(Specify)
(e) Means of injury

23. Signature Francis M. Grant M.D.
Address Union Memorial Hosp Date signed 11-19 18

VS 150

66890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66890

469 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Ethel St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Parker
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-03-6825

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Naomi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1899

8. AGE: Years 49 | Months 4 | Days 27 | If less than one day: hr. min.

9. Birthplace Cambill, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Herbert L. Parker
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Janie Johnson
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. Naomi Parker
(b) Address 2204 Ethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/1948 (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location Baltimore, Md.

18 (a) Funeral director George H. Copeland
(b) Address 1623 Druid Hill Ave.

19 (a) NOV 25 1948 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1948 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-11 1948 to 11-27 1948 and that I last saw him alive on 11-24 1948

Immediate cause of death	Duration
Metastic Carcinoma & Gastric Hemorrhage	
Due to Duodenal Ulcer	
Due to Carcinoma of Pancreas	
Other Conditions	

(Specify pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Brightbower
Address University Hospital Date signed 11-27-48

V8 150

X

068911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1176

068911

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Sterling (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Rollins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Hazel Rollins
6 (c) If alive, give age 4-4 years

7. Birth date of deceased (mo., day, yr.) 6-3-87

8. AGE: Years	Months	Days	If less than one day
61	5	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Nathaniel Rollins
13. Birthplace ?

MOTHER
14. Maiden Name Sara Pomeroy
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 28 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union cemetery
Location Leesburg, Va.

18 (a) Funeral director John D. Mitchell
(b) Address Baltimore, Md.

19 (a) NOV 25 1948 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 4 25 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-20 1948 to 11-25 1948, and that I last saw him alive on 11-25 1948

Immediate cause of death: Massive upper Gastro-intestinal hemorrhage — Duration

Due to Duodenal ulcer

Due to

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Duodenal ulcer, arteriosclerosis, splenomegaly, cardiomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. D. Jackson M.D.
Address The Johns Hopkins Hospital Date signed 11/26/48

VS 150

Meehan

68912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 68912

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw & Walkers Ave.

(c) Hospital or institution: Jenkins Memorial 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 524 Valley St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Meehan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John Meehan

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1869

8. AGE: Years	Months	Days	If less than one day
79	3	0	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dermod Thomas Ellis
13. Birthplace Ireland

MOTHER
14. Maiden Name Dermod Maria Everson
15. Birthplace Ireland

16 (a) Informant Mrs. Esther J. Meehan
(b) Address 1519 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Coghlan
(b) Address 924 E. Eager St.

19 (a) NOV 25 1948 (Date rec'd by registrar) Clinton Williams M.D. (Registrar)
(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1948, at 3 00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1939 to Nov. 25 1948, and that I last saw her alive on Nov. 25 1948.

Immediate cause of death Congestive failure — Duration

Due to ~~Of~~ Arteriosclerotic hypertensive CVD

Due to

Other Conditions Old cerebrovascular accident
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Herbert J. Lenchan, M.D.

Address St. Agnes Hosp. Date signed 11/25/48

VS 150

Physicians: please write the causes of death clearly and legibly. Any important

668913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 668913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta M. Yost

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Female	White	Married

6 (b) Name of husband or wife John W. G. Yost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 14 1883

8. AGE: Years	Months	Days	If less than one day
65	8	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Grace A. Hamilton
15. Birthplace Ireland

16 (a) Informant John W. G. Yost
(b) Address 6 N Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) NOV 25 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Nov. 24 1948, and that I last saw her alive on Nov. 24 1948.

Immediate cause of death	Duration
Carcinoma of liver	
Due to metastasis from Carcinoma stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1947 - 3 times
Major findings of operation: Ca of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Charles C. MacMillan M.D.
Address 29 E. Eutaw St Date signed Nov. 26

VS 150

(68914) (68914)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. If any item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2053 Gough Street
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2053 Gough St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Rose Conrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/22/85

8. AGE: Years	Months	Days	If less than one day
63	3	2	hr. min.

9. Birthplace Baltimore · Md. (Town, county, and state)
10. Usual Occupation Metal Worker
11. Industry or business

FATHER
12. Name Martin Miller
13. Birthplace Balto

MOTHER
14. Maiden Name Mary ?
15. Birthplace Balto

16 (a) Informant Rose Miller
(b) Address 2053 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 N. Wolfe St.

19 [a] Filed NOV 25 1948 (b) Huntington Williams, M.D. Registrar

NOV 25

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/ 1948, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1948, to Nov. 24 1948, and that I last saw h[illegible] alive on Nov. 24 1948.

Immediate cause of death
Pulmonary Edema
Arterio sclerotic Heart Disease
with myocardial insufficiency
Due to Generalized hypostatic congestion
Obesity
Due to

Duration
2 days.
7 days.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Geo. N. Lefevre M. D.
Address 422 S. Eutaw St. Date signed 11/26/48

G68915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68915 Registered No. 3694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 Stricker St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Stricker St.
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Henson
3 (b) If veteran, name war —
3 (c) Social Security Account No. unknown

4. Sex: Male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs Alberta Henson
6 (c) If alive, give age 52 years

7. Birth date of deceased mo. August day, yr. 1895
8. AGE: Years 53 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation plasterer
11. Industry or business —

FATHER
12. Name Charles W. Henson
13. Birthplace Baltimore md

MOTHER
14. Maiden Name Rose Dennis
15. Birthplace Md

16 (a) Informant Mrs Alberta Henson
(b) Address 217 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman ST

19 NOV 25 1948 (Date rec'd by registrar) (b) Huntington Mitchell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 24 - 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17-1948, to 11-24-1948, and that I last saw him alive on 11-25-1948

Immediate cause of death: Pneumonia, bilateral — Duration: 1 wk

Due to

Due to

Other Conditions Hypertension — 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 11-25-48

VS :53

668916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Asquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS WILLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1903

8. AGE: Years	Months	Days	If less than one day
45	5	14	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name -- --
13. Birthplace

MOTHER
14. Maiden Name ------
15. Birthplace

16 (a) Informant Clarence Barnes
(b) Address 301 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director THOMAS E. KELSON
(b) Address 1303 Pressman St.

19 (a) [illegible] 25 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948, at 4:32PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/25/48

G68917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 South Augusta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Augusta ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolphus Aden Anderson.
3 (b) If veteran, name war 1
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1948, at 8 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to Nov 24 1948.
and that I last saw him alive on Nov 24 1948.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married.

6 (b) Name of husband or wife Lillian Anderson
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug 29 1897

8. AGE: Years	Months	Days	If less than one day
51	2	26	hr. min.

9. Birthplace Maryland. (City, county, and state)
10. Usual Occupation
11. Industry or business Tuttle Oil Co.

FATHER
12. Name Aden S Anderson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Maydee Bunkler
15. Birthplace Maryland

16 (a) Informant Mrs Lillian Anderson
(b) Address 20 South Augusta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Maternal Cemetery
Location Back City

18 (a) Funeral director Edward McGrath
(b) Address Catonsville, Md

19 NOV 25 1948 (Date rec'd by registrar) (b) Twenting for Williams, M.D. Registrar

Immediate cause of death Carcinomatosis

Due to Carcinoma of Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex H. Cranston M. D.
Address 4009 Harford Ave Date signed 11/26/48

V3.3

68918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. G68918

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 W. FRANKlin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 W. FRANKlin (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Hubbard Fitchett

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-5944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Bessie Fitchett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76yrs.	2	-		

9. Birthplace EASTville, VA. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Colup Fitchett
13. Birthplace EASTville, VA.

MOTHER
14. Maiden Name Ann Fisher
15. Birthplace EASTville, VA.

16 (a) Informant FANNIE Fitchett Wallace
(b) Address 130 W. FRANKlin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)
(c) Cemetery or crematory Orchestus Mem Park
Location Baltimore Md

18 (a) Funeral director Samuel L Bloom Sr
(b) Address 1628 Montgomery St (b) Huntington Williams, M.D.

NOV 25 1948 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-1948, to 11-23, 1948, and that I last saw him alive on 11-22-1948.

Immediate cause of death CARDIAC Failure — Duration week

Due to CARDio-renal disease — 7wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St Date signed 11-24-48

VS 150

(68919

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 94a

Registered No. 68919

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Woodridge Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Woodridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas G. Reinhart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katie Margaret Woodey | 6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) July 1, 1881

8. AGE: Years 67 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Post office

FATHER
12. Name Henry Reinhart
13. Birthplace Md

MOTHER
14. Maiden Name Caroline —
15. Birthplace —

16 (a) Informant Earl E. Reinhart
(b) Address 3919 Woodridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1948 (month) (day) (year)
(c) Cemetery or crematory London Pk
Location 3801 Frederick Rd

18 (a) Funeral director Henry H. Meintzer
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 10¾ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1948 to 11-25 1948, and that I last saw him alive on 11-25 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to Coronary arteriosclerosis

Due to

Other Conditions Pernicious anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Ldape M. D.
Address 3921 Edmondson Date signed 11-26-48

VS 150

H. W. Ldape

G68920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G68920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AUGUST MESNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 9, 1870

8. AGE: Years	Months	Days	If less than one day
78	9	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Mesner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Muller
15 Birthplace

16 (a) Informant Mrs Margaret Foster
(b) Address 2522 E. Eager St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (c) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 at 9:00 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 19 48 to 11/24 19 48 and that I last saw him alive on 11/23 19 48

Immediate cause of death: hypostatic pneumonia, myocardial insufficiency — Duration 3 days.
Due to
Due to
Other Conditions arterio-sclerosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature L. C. Goldsborough
Address 447 N. Kenwood Ave. Date signed 11/24/48

VS 150

G68921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G68921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 W. Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) FULL NAME Minnie L. Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph Doyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1885

8. AGE: Years	Months	Days	If less than one day
63	4	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Spencer
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorn ?
15. Birthplace Maryland

16 (a) Informant Thomas S. Wright
(b) Address 2518 W. Fayette Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1948 to Nov 24, 1948, and that I last saw h[illegible] alive on Nov 23, 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardiovascular disease	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffee
Address 3101 W Baltimore St Date signed 11/26/48

VS 139

668922 BALTIMORE CITY HEALTH DEPARTMENT 668922

CERTIFICATE OF DEATH

97 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home For the Aged Blvd
(c) Hospital or institution: 1200 Valley St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1908 Casadell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maze Driscoll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Henry Driscoll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 4 1881

8. AGE: Years	Months	Days	If less than one day
67	8	20	hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Frederick Zimber
13. Birthplace Penna.

MOTHER
14. Maiden Name Maggie Devine
15. Birthplace Penna.

16 (a) Informant Sister Linda [illegible] Lee
(b) Address 1200 Valley

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. J. Semmes
(b) Address 4611 Park Heights

19 (a) NOV 28 1948 (b) Huntington Ave Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1948, to Nov 24 1948, and that I last saw her alive on Nov 23 1948

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Arteriosclerosis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature E. Lockard M. D.
Address 6312 North Ave Date signed 11/27/48

VS 150

68363 BALTIMORE CITY HEALTH DEPARTMENT 68363

CERTIFICATE OF DEATH 942

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Linden Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Withers

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Matilda E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1891

8. AGE: Years	Months	Days	If less than one day
57	2	5	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation motorman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Wm. T. Withers
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Schmal
15. Birthplace Md

16 (a) Informant Mrs. Matilda E. Withers
(b) Address 1730 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St.

NOV 29 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Nov. 1948, at 7.05 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner.
Date signed 25 Nov. 1948

VS 151

Accompanying diagrams: physicians please write the causes of death clearly and legibly.

668924
JL. 124776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife Hazel Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1900

8. AGE: Years	Months	Days	If less than one day
48 yrs.	8	27	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Balto. City Swimming Pool

FATHER
12. Name Robert Wilson
13. Birthplace Penna.

MOTHER
14. Maiden Name Jennie Laughn
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Rosedale
Location Martinsburg, W. Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Balto., Md.

19 (a) NOV 25 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 10.30 Am

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 22 1948 to Nov. 23 1948, and that I last saw him alive on Nov. 23 1948

Immediate cause of death: Pulmonary edema.
Due to: acute left ventricular failure
Due to: severe anemia
Other Conditions: Arteriosclerosis Leukemia Massive Doctrine bleeding
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature William H. Hunter M.D.
Address Balto City Hosp Date signed 24 Nov 48

VS '50

731

668925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Days

2. USUAL RESIDENCE OF DECEASED: Same
(a) State Md. (b) County Talbot
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakley St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Dr. HENRY TAWES, M.D.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Winnie Leach
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): December 4, 1879
8. AGE: Years: 68 Months: 11 Days: 21 If less than one day: hr min
9. Birthplace: Crisfield, Maryland (Town, county, and state)
10. Usual Occupation: physician
11. Industry or business

FATHER
12. Name: Leonard Smith Tawes
13. Birthplace: Accomac County, Va.

MOTHER
14. Maiden Name: Mary Lawson
15. Birthplace: Accomac, County, Va.

16 (a) Informant: Granville LeCompte
(b) Address: Cambridge, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery: Old Trinity
Location: Church Creek, Maryland

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place, Baltimore, Md.

19 (a) (Date received by Registrar) NOV 29 1948 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948 at 11:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-16-48 to 11-25 1948 and that I last saw him alive on 11/25/48

Immediate cause of death: cardiac failure — Duration

Due to: uremia, myocardiosis, infarction

Due to: arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John LoCasto M. D.
Address: Univ. Hosp. Date signed 4-26-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Only one cause on a line.

668926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

668926 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 St. James St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BRYANT CAMPHARS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1916

8. AGE: Years	Months	Days	If less than one day
42	32 smt 4		hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Stanen Camphars
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Luline ?
15. Birthplace Unknown

16 (a) Informant Mable Alexander
(b) Address 1216 St. James Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1006 Pennsylvania Ave

19 NOV 27 1948 (b) Huntington Williams, M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 9:55 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cystitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D. (Medical Examiner)
Date signed November 23, 1948

VS 151

X

G68927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3735 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3735 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DR. SAMUEL WEINBERG.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Frances Weinberg.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880.

8. AGE: Years	Months	Days	If less than one day
68		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician.
11. Industry or business

FATHER
12. Name Nathan Weinberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Hester Kaufman,
15. Birthplace Germany.

16 (a) Informant Mrs. Frances Weinberg,
(b) Address 3735 Park Heights Ave.

17 (a) Burial (b) Date thereof 11/28/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) NOV 29 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1948 to Nov. 26, 1948. and that I last saw h[illegible] alive on Nov. 25 1948.

Immediate cause of death	Duration
Coronary Artery Disease	1 mo
Due to Arteriosclerosis	
Due to	
Other Conditions Chr. Bronchitis Bronchiectasis	5 yrs +

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. S. Shiling M. D.
Address 2426 Eutaw Place Date signed

M. S. SHILING

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

G68928 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Whittier Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARIE ANN MONNESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Arthur Monness
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1906

8. AGE: Years	Months	Days	If less than one day
42	7	11	hr. 12 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Julius Farbman
13. Birthplace Russia

MOTHER
14. Maiden Name Frances Tramer
15. Birthplace Philadelphia, Pa.

16 (a) Informant Julius Farbman
(b) Address 2208 Whittier Avenue

17 (a) Burial (b) Date thereof Nov. 28/ 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E. Baltimore Street
18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

(a) Date received by registrar NOV 29 1948 (b) Registrar Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31/48 19 to 11/26/48 19 and that I last saw h alive on 11/26/48 19

Immediate cause of death	Duration
Due to Lupus erythematosus disseminated	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. M. Kestner M. D.
Address 3006 N. Dillon Date signed 11/29/48

Correct all items carefully. Physicians: please write the causes of death clearly and legibly. Especially important.

668929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

668929
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Baltimore Hosp.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 S. Mulberry St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM RICKARD

3 (b) If veteran, name war: W.W. II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1923

8. AGE: Years 25 | Months | Days | If less than one day: hr. min.

9. Birthplace Hagerstown Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Max Rickard
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Lillian Walsh
15. Birthplace Ireland

16 (a) Informant Mrs Rickard
(b) Address Hagerstown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 48 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md

18 (a) Funeral director C. M. Snider & Son
(b) Address Hagerstown

19 (a) Nov 29 1948 (b) Registrar Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1948 at 10:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov. 26 1948, and that I last saw him alive on Nov 26 1948

Immediate cause of death: Granulomatous lymphoid extradural spinal tumor

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Auld, M.D.

Address Univ. Hosp. Date signed 11/29/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

Registered No. 68930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenue
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Gwynn Oak Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy M. Horney

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James N. Horney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/28/1913

8. AGE: Years	Months	Days	If less than one day
35	2	28 29	hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Garnet Wickham
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Hayden
15. Birthplace Md.

16 (a) Informant Mr. James N. Horney
(b) Address 5001 Gwynn Oak Ave.

17 (a) Woodlawn (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves.

NOV 27 1948 (Date rec'd by registrar) (b) Washington Wilkins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 1948, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/ 1948 to 11/26/ 1948, and that I last saw her alive on 11/26/ 1948.

	Duration
Immediate cause of death CARCIN- OMA RESPIRATORY FAILURE	
Due to MULTIPLE MYELOMA	
Due to CLOUDY SWELLING KIDNEYS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: PS NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James N. Horney M. D.
Address St. Agnes Hosp. Date signed 11/29/48

Age is especially important. Physicians: please write the causes of death clearly and legibly.

Mb4 668931 BALTIMORE CITY HEALTH DEPARTMENT ✓ 668931

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Amarillo (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Hayden Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Francis W. Popham

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude T. Popham
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr): 12-14-75

8. AGE: Years 72 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace: Kansas (Town, county, and state)
10. Usual Occupation: Rancher
11. Industry or business: Self

FATHER
12. Name: Elias Popham
13. Birthplace: Indiana

MOTHER
14. Maiden Name: Elizabeth Finsey
15. Birthplace: Indiana

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory
Location Amarillo, Texas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 27 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1948, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948 to 11-26 1948.
and that I last saw h[illegible] alive on 11-26 1948.

Immediate cause of death: Leukemia, myeloblastic, subleukemic, acute — Duration: 4 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Bell M. D.
Address Johns Hopkins Hosp Date signed Nov 26, 48

VS 150

G 3932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82a

G68932
Registered No.

Please write the causes of death clearly and legibly. Physicians especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR O. BABENDREIER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower.

6 (b) Name of husband or wife: Ada Babendreier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1870

8. AGE: Years	Months	Days	If less than one day
78	10	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Albert Babendreier
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia
15. Birthplace Germany

16 (a) Informant Mrs. Juliana S. Trautmann
(b) Address 3020 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, (c) 48 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1948 to Nov 26 1948 and that I last saw him alive on Nov 25 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 mos.
Due to: General Arteriosclerosis	5 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen F. Pullman M. D.
Address 6 E Biddle St Date signed 11-27-48

VS 150

668933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

668933 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 McDonogh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
CHARLES E. WELLS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-4980

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1898

8. AGE: Years 50 yrs. | Months 2 | Days 25 | If less than one day hr. min

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Edward Wells
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Baltimore, Maryland

16 (a) Informant: Burdella Cunningham
(b) Address 2618 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 27 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calay
Location Balti. Md.

18 (a) Funeral director Walter B. Spriggs
(b) Address 139 W. Hamburg St.

19 (a) 1948 (Registered by registrar) Washington Williams, Registrar

29

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948 at 3:12 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edgar T. Ward M.D.
Medical Examiner.

Date signed 11-22-48

Please give age if propriety imposes it. Physicians: please write the causes of death clearly and legibly.

66893-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

66893-1

Registered No. 1212

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 Frederick Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver E. Mitchell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-09-4752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nannie E.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 12-20-1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	10	4		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Louden Park Cem. Co.

FATHER
12. Name Luther A. Mitchell
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Hanicke
15. Birthplace Maryland

16 (a) Informant Nannie E. Mitchell "wife"
(b) Address 3801 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 27 Nov. 48 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore - Md.

18 (a) Funeral director W. B. Hilbert & Son
(b) Address 1900 Eutaw Place

NOV 27 1948 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 - 1948 at 11:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 21 1948 to Nov 24 1948 and that I last saw h. alive on Nov 24 1948.

Immediate cause of death	Duration
Hypertensive Arterio Sclerotic Renal Disease with Uremia & Convulsions	16 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3833 W North Ave Date signed Nov 27 1948 M.D.

G68935

ES-124e15

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7200 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Leone (VITO LEONE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Elizabeth LEES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1894

8. AGE: Years	Months	Days	If less than one day
54	-	23	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation BARBER
11. Industry or business SELF

FATHER
12. Name Vincent Leone
13. Birthplace Italy

MOTHER
14. Maiden Name Angelina Delmonte
15. Birthplace New York

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Dorheavn Cem
Location Eastern Ave.

18 (a) Funeral director J. J. Fahey & Son
(b) Address 218 Light St. Huntington Williams, M.D.

19 (a) NOV 27 1948 (b) (Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 1948 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-25 1948 and that I last saw him alive on 11-25 1948

Immediate cause of death	Duration
Hemorrhage from ecrotum	
Due to Abdominal aortic aneurysm rupturing	
Due to syphilis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Osborne

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Haden M. D.
Address Balto City Hosp. Date signed 26 Nov 48

VS 150

G6893.36

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G6893.36
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Roland Ave Balto 10
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Mennis Lawson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	212-01-8801	Male	White	Married

6 (b) Name of husband or wife Mrs. Margaret Lawson
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	3	0		

9. Birthplace Banks Garden, Virginia
(Town, county, and state)
10. Usual Occupation Real Estate
11. Industry of business

FATHER
12. Name Robert Lawson
13. Birthplace Virginia

MOTHER
14. Maiden Name Grace Waters
15. Birthplace Virginia

16 (a) Informant Mrs. Margaret Gullette Lawson
(b) Address 5203 Roland ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Wytheville
Location Wytheville, Virginia

18 (a) Funeral director Francis Sisson
(b) Address Huntington West Virginia

19 (a) NOV 28 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 4 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1948, to Nov. 27 1948, and that I last saw him alive on Nov. 26 1948

Immediate cause of death Myocardial Failure — **Duration**

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature H. C. Graybeal M.D.
M. D.
Address Union memorial Hospital Date signed 11-27-48

VS 150

6689.37 ES-120371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

✓ 6689.37 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Ridgley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Ruhland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 1, 1876

8. AGE: Years	Months	Days	If less than one day
72	5	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Ruhland
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Wagoner
15. Birthplace Del.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 / 27 / 48 (month) (day) (year)
(c) Cemetery or crematory Cook Hill
Location Rockville Pike

18 (a) Funeral director John F. Denny, Inc
(b) Address 715 Light St -30

19 (a) NOV 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 19 48 at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 19 48 to 11-19 19 48 and that I last saw him alive on 11-19 19 48

Immediate cause of death Carcinoma of lung & metastases — Duration 1 year?

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 6-16-48 8-22-48

Major findings of operation: Biopsies of metastatic carcinoma of lung

of autopsy: not obtained

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature David H. Marine M. D.
Address Balto City Hosp Date signed 11-27-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

668938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124a

668938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm, Mrs. Wm W.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace V
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1867

8. AGE: Years	Months	Days	If less than one day
81	9	-	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Farm

FATHER
12. Name Jacob B Wilhelm
13. Birthplace Md

MOTHER
14. Maiden Name Angelina Healy
15. Birthplace Md

16 (a) Informant Mrs Wm W Wilhelm
(b) Address Parkton Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 30/48 (month) (day) (year)
(c) Cemetery or crematory Forestview
Location Baltimore Md

18 (a) Funeral director Edward Tipton
(b) Address Hampstead Md

19 (a) Nov 28 1948 Entered by Williams, MD
(Not to be filled in by Registrar) Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1948, to 11-27 1948, and that I last saw him alive on 11-27 1948.

Immediate cause of death
Respiratory Failure
Cardiac Failure

Duration

Due to
Poss coronary thrombosis

Due to

Other Conditions Renal calculus
dept ?
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Rimmenberger M.D.
Address Univ. Hosp Date signed 11-27-48

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use

G689.39

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G689.39
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES L. BEATTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1881

8. AGE: Years	Months	Days	If less than one day
67 yrs.	2	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business McDowell Candy Company

FATHER
12. Name James Beatty
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Julia L. Beatty
(b) Address Linthicum Post Office, Md.

17 (a) Burial (b) Date thereof 11/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson & Longwood Sts

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 & 3 Hollins Street

19 (a) NOV 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Ruzzo M.D.
Medical Examiner.
Date signed 11/24/48

VS 151

G68940

GM. 124793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G68940

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 657½ W. Lexington St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Bleuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 13, 1902

8. AGE: Years	Months	Days	If less than one day
46	7	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Koesters Bakery

FATHER 12. Name Charles Bleuel

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Caplin

15. Birthplace Germany

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 11/30/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Kentucky Ave + Belair Rd

18 (a) Funeral director John J. Cowan & Son

(b) Address 2011-03 Hollins St. Huntington Williams, MD

19 (a) NOV 28 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1948 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1948 to 11-26 1948.

and that I last saw him alive on 11-26 1948.

Immediate cause of death Cardiac failure

Due to Subacute bacterial endocarditis

Due to congenital aortic valvular anomaly

Other Conditions 0

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William H. Vieten, Jr. M. D.

Address Balto City Hosp Date signed Nov 28

VS 199

Keep important: Physicians: please write the causes of death clearly and legibly.

G68941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68941

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 N. Calvert Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NO

3 (a) FULL NAME Miss Nannie Belle Brown (Miss Nannie Belle Brown)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife XXXXXXXXXXX

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) abt. 7/27/1873

8. AGE: Years: about-75 | Months: 3 | Days: 29 | If less than one day: hr. min

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired - Baltimore City

11. Industry or business Public School Teacher

FATHER
12. Name John Wesley Brown
13. Birthplace Waverly, King George Co., Va.

MOTHER
14. Maiden Name Nannie Stone Turner
15. Birthplace Yalton, Charles Co., Maryland

16 (a) Informant Miss Daisy D. Ashton (Niece)
(b) Address Potomac Beach, Westmoreland Co. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Church Cemetery
Location King George County, Virginia

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Av., Balto. 1. Md.

19 (a) (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov. 1948, at 10:37 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to Hypertensive Cardio-Vascular Disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, M.D. Medical Examiner.
Date signed 27 Nov. 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68942 ✓ G68942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4814 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✗
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4814 Frederick Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Herman Charles Schindle

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-09-8087

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1885

8. AGE: Years: 63 | Months: — | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Herman Schindle
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine A. Lyssey
15. Birthplace Germany

16 (a) Informant John Holdy
(b) Address 230 f Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schmidt
(b) Address 2401 Frederick Ave.

19 (a) NOV 28 1948 (Date received by registrar) Registrar

VS-130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to Nov 25 1948, and that I last saw him alive on Nov 25 1948.

Immediate cause of death: Death Coronary Thrombosis — Duration: 1 minute

Due to: Coronary Sclerosis — Duration: years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. J. Mendelis

Address 6511 R Bentalou Date signed 11/26/48 M D

668943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

668943 Registered No.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2461 Westport St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2461 Westport St
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MINNIE B. FREEMAN

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Wm. H. Freeman
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) July 29, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	28	hr. min.

9. Birthplace Anne Arundel Co. Md
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Marshall
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Eliza Baldwin
15. Birthplace A. A. Co. Md

16 (a) Informant William N. Freeman
(b) Address 2461 Westport St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn Cem
Location Annapolis Md

18 (a) Funeral director Wm. Md. John W. Tuttle & Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 28 1948 (b) Name rec'd by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1948, at 10:41 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Nov 26 19 48 and that I last saw h[illegible] alive on Nov 25 19 48.

Immediate cause of death Carcinoma of Breast — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Paul Thompson M.D.
Address 301 Arnold Date signed 11-28-48

X

G68944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G68944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 W. FAYETTE ST
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 59 YRS 7 MOS residing

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 W FAYETTE ST (If rural give location)
(e) Citizen of foreign country? NO Yes or No
If yes, name country

3 (a) FULL NAME Catherine Elizabeth Summers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	MARRIED

6 (b) Name of husband or wife George Thomas
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 25 1889

8. AGE: Years	Months	Days	If less than one day
59	7	2	— hr. — min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business own home

FATHER
12. Name Henry Blum
13. Birthplace Germany

MOTHER
14. Maiden Name Thelma — ?
15. Birthplace Germany

16 (a) Informant MRS. Doris Stevens
(b) Address 631 N. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore City

18 (a) Funeral director Mrs. Jno. M. Tetterton
(b) Address 5311 Edmondson Ave.

19 (a) NOV 28 1948 (b) Huntington Williamson, M.D. (Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948 at 12.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to November 27 1948, and that I last saw her alive on November 26 1948

Immediate cause of death: Bronchopneumonia — Duration: 24 hrs.

Due to: Cardiac Failure — 3 days ?

Due to: Chronic Myocarditis & Myocardial Degeneration

Other Conditions: Secondary Anemia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 11/27/48

VS 150

G68945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W North Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 r
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Duffy

3 (b) If veteran, name war No | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eleanor T. D. Duffy | 6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Nov-23-1852

8. AGE: Years 86 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business Law

FATHER 12. Name Edward Duffy

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Emma C. McMillan

15 Birthplace Balto Md.

16 (a) Informant Mrs Henry Duffy - (wife)

(b) Address 110 W North ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Elliott City

18 (a) Funeral director Edward Mayer & Co.

(b) Address 108 W North Ave.

19 (a) (Date received by Registrar) NOV 28 1948 (b) Registrar's No. Transcript for Will

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to November 1948, and that I last saw h[illegible] alive on Nov. 25 1948.

Immediate cause of death: Hemiplegia

Due to: arteriosclerosis.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Lumbert Ford

Address 20 E. Preston St — Date signed 11/29/48

VS 150

668946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Boarman Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Galek

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Elaine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Auto mechanic

11. Industry or business

FATHER 12. Name John Galek
13. Birthplace Poland

MOTHER 14. Maiden Name Agnes Janicko
15. Birthplace Poland

16 (a) Informant Elaine Galek
(b) Address 2907 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) NOV 28 1948 (Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1948 at 3-30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-27-48 at 1:30 A. M.
(b) Where did injury occur? Broadway & Hoffman St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public place While at work? No
(d) Means of injury Auto struck bridge support

23. Signature [illegible] M.D. (Medical Examiner)
Date signed 11-29-48

Tuntington Hotel Baltimore, Md

CORRECTED 1-11-49

G689:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

G689:7

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Typewriting is preferred.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 706 Mortonia Rd

(c) Hospital or institution: The Mount

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County

(c) City or town New York (If outside city or town limits, write RURAL, and give town)

(d) Street No. Lambs Club (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clyde Veaf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Actor

11. Industry or business

FATHER 12. Name: David

13. Birthplace: Russia

MOTHER 14. Maiden Name: Rosa

15. Birthplace: Russia

16 (a) Informant: Irving Silverman

(b) Address: 2710 Osweyo Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-29-48 (month) (day) (year)

(c) Cemetery or crematory: Adas Israel

Location: Washington, D.C.

18 (a) Funeral director: Jack Levos Inc

(b) Address: 2400 Eutaw Place

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1948, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 1948, and that I last saw him alive on Nov 26 1948.

Immediate cause of death	Duration
Carcinomatosis	8 mo
Due to Carcinoma of sigmoid	10 mo
Due to Carcinoma of Prostate	3 yr.

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence a: M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lester A. Kolman M.D.

Address 3700 Dark Neck Rd Date signed Nov 27 1948 M D

Lester A. Kolman

VS 150

G68948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G68948
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Fruma Meyers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Haskel
13. Birthplace Russia

MOTHER
14. Maiden Name Emma
15. Birthplace Russia

16 (a) Informant Mrs Mary Hoffman
(b) Address 2901 Thorndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Kewy Inc
(b) Address 2406 Eutaw Place

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26th 1948 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13th 1948 to Nov 26th 1948. and that I last saw her alive on Nov 26 1948.

Immediate cause of death	Duration
Chronic cardio vascular disease	
Due to	
Due to	
Other Conditions General Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.
Address Levindale Home Date signed 11/26/48

Penalty for wilfully making a false statement, with UNDERSTANDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington Williams, M.D.

G68949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3457 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Lath (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Lath
13. Birthplace

MOTHER 14. Maiden Name not known
15. Birthplace Latty

16 (a) Informant Joseph Smith
(b) Address 3457 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Gully Rd & Hamilton Ave

18 (a) Funeral director Leek Lewis Inc
(b) Address 2100 Eutaw Place
Baltimore 17, Md.

NOV 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20/48 19 to 11/26/48 19 and that I last saw her alive on 11/25 19

Immediate cause of death Myocardial infarction — Duration

Due to arterio-sclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Young M. D.
Address U. of B. Hospital Date signed 11-27

VS 100

668950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

668950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Broadway # 3) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL SILVERSTEIN
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife ADA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 68 | Months | Days | If less than one day hours min.
9. Birthplace Roumania (Town, county, or state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name not known
13. Birthplace Roumania

MOTHER
14. Maiden Name not known
15. Birthplace Roumania

16 (a) Informant Ada Silverstein
(b) Address 22 So Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2120 Eutaw Place

19 (a) Date received by (registrar) NOV 28 1948 (b) Filing for Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 November 1948 at 12:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 21 1948 to Nov 27 1948 and that I last saw h[illegible] alive on November 26 1948

Immediate cause of death: Cerebrovascular Hemorrhage — Duration
Due to
Due to
Other Conditions: Benign Prostatic Hypertrophy, Arteriosclerotic Coronary Artery Disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellen Robert Golan M.D.
Address SINAI Hospital Date signed 11/27/48

VS 193

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66893-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

66893-1 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3133 Oakford Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME DISTILLER, Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Distiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired merchant
11. Industry or business

FATHER
12. Name Melowe
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Mary Distiller
(b) Address 3100 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 NOV 28 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 5.55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1946 to Nov 27 1948
and that I last saw h alive on Nov 27 1948

Immediate cause of death: Hypertensive Cardiovascular Disease — Duration 2 yrs
Due to: Cardiac Enlargement — 2 years
Due to: Congestive Failure — 2 days
Other Conditions: Pulmonary Edema — 2 days
(Including pregnancy within three months)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature A A Wendroff M.D.
Address 4603 Park Ave Date signed 11-29-48

VS 150

658952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 66892

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town ORANGEBURG, (If outside city or town limits, write RURAL and give town)
(d) Street No. 361, Park, Ave. N.E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas . R. Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-28-48

8. AGE: Years	Months	Days	If less than one day
	1	28d	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Henry Moore
13. Birthplace S.C.

MOTHER
14. Maiden Name Melba Redman
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Memorial Gdns.
Location Orangeburg S.C.

18 (a) Funeral director Ulmer Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Lemuel Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 28 1948 at 2 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1948 to 11-28- 1948. and that I last saw him alive on 11-28- 1948.

Immediate cause of death	Duration
Heart failure	
Due to Congenital malformation of heart	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harriet G. Cried M.D.
Address Johns Hopkins Hospital Date signed 11/28/48

6689:53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 6689:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOU EMMA CLYBURN

3 (b) If veteran, name war ———

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Wyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9,

8. AGE: Years	Months	Days	If less than one day
33	6	..	hr. min.

9. Birthplace Lancaster, S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James McKenney
13. Birthplace Lancaster, S. C.

MOTHER
14. Maiden Name Maggie Foster
15. Birthplace Lancaster, S. C.

16 (a) Informant Mary E. Nicholson
(b) Address 405 N. Carrollton Avenue

17 (a) Shipley (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Lancaster S. C.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3299 Saratoga St Huntington Williams, W.

19 NOV 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 11:32 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or secondary ☐ cause of death, fill in the following:
(a) Date of injury 11-25-48 at Approx. 11 P. M.
(b) Where did injury occur? 670 W. Saratoga Street
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? No
(d) Means of injury Firearms

23. Signature E. L. Royer M.D. for H. A. Merrill M.D. Medical Examiner.
Date signed 11/27/48

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH
   Baltimore City, Maryland
   a. Street address
   b. Hospital or institution

2. USUAL RESIDENCE OF DECEASED
   a. Street No.
   b. City or town
   c. Length of stay in hospital or institution, years, months, or days
   d. Length of stay in Baltimore, years, months, or days

3. FULL NAME

5. If veteran, name war

Social Security Account No.

MEDICAL CERTIFICATION

4. Sex

5. Color or race

6. Single, married, widowed, or divorced

Name of husband or wife

7. If married, widowed, or divorced, how long in present marriage

8. AGE: Years, Months, Days. If less than one day

20. DATE OF DEATH

21. I hereby certify that I attended the deceased from

to

that I last saw h

Immediate cause of death

Duration

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

Date of operation

Major findings of operation

Autopsy

PHYSICIAN

Physicians please write the cause of death clearly and legibly

Place

Remington Baltimore Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1 PLACE OF DEATH

Baltimore City, Maryland

Street address

If Hospital or institution

2 USUAL RESIDENCE OF DECEASED

a State

b Street No.

c Length of stay in hospital or inst. yrs., mos., or days

Length of stay in Baltimore yrs., mos., or days

3 FULL NAME

3a If veteran, name war

3b Social Security Account No.

4 Sex

5 Color or race

6 If Single, Married, Widowed or Divorced

7 Name of husband or wife

8 Birth date (If dead, give age)

8 AGE Years Months Days If less than one day

9 Birthplace

10 Usual Occupation

11 Industry or business

MOTHER FATHER

12 Name

13 Birthplace

14 Maiden Name

MEDICAL CERTIFICATION

20 DATE OF DEATH M

21 I certify that I attended the deceased from to and that I last saw h alive on

Immediate cause of death

Duration

Due to

Due to

Other Conditions

PHYSICIAN

Date of operation

Major findings of operation

Date of autopsy

Where buried

Undertaker

Address

Signature

Knott — Contington, Baltimore, Md.

Physicians, please write the cause of death clearly and legibly

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. J L*- 120459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Broadway Ave.
(c) Hospital or institution
Baltimore City Hospitals
(d) Length of stay in hospital or inst. yrs., mos., or days 17 days
(e) Length of stay in Balt. more yrs. mos. or days 63 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State [illegible]
(b) City or town
(c) Street No. 1139 Eastlake St.
(d) Citizen of foreign country
Born in what country

3. FULL NAME Ella Marsh

4. Sex F | Color or race W | Single, married, widowed or divorced Widow

5. Name of husband or wife

6. If married, widowed or divorced, name of husband or wife

7. Birthdate of deceased June 20, 1872

8. AGE Years 75 Months 4 Days 7

9. Birthplace Mich.

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name [illegible]

13. Birthplace Mich.

14. Maiden Name [illegible]

15. Birthplace Mich.

16. Informant [illegible] Address 340 Broadway Ave.

17. Burial Date thereof July 30, 4
Cemetery or crematory [illegible]
Location [illegible]

18. Funeral director [illegible]
Address [illegible]

19. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27.

21. I hereby certify that I attended deceased from July 27. to July 27.

Immediate cause of death
Calcinosis
Due to Acute carditis
Syphilis

Contributory

Operation Autopsy?

Date of operation 7/26/28
Major findings of operation As above

PHYSICIAN

of autopsy

Accident, suicide or homicide

(a) Date of occurrence at M
(b) Where did injury occur
(c) Did injury occur in or about home, factory, street, farm or other place specified
City

Manner

23. Signature [illegible]
Address 340 Broadway 11/27/28

Coroner's Agent to personally investigate. Physician to fill out the above death report and hand to undertaker.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1 PLACE OF DEATH

1,100 N. Caroline St.

St. Joseph's

3 FULL NAME

Joseph Henry Lee

No No Nine

Single

M. M.

about 8

Approx. 60

Baltimore

None

Michael Lyo.
Ireland
Anne E Cree
England
Clara Lee
611 E Fair
Burial

20 DATE OF DEATH

Immediate cause of death

Generalized arteriosclerosis
with cerebral arteriosclerosis

Osteoarthritis
Decubitus ulcer
Malnutrition

PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH
   a. Baltimore City, Maryland
   b. Street address [illegible] Light St.
   c. Hospital or institution [illegible]
   d. Length of stay in hospital or inst. yrs., mos., or days [illegible]
   e. Length of stay in this county yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. No. [illegible]
   b. [illegible] Baltimore
   c. [illegible]

3. FULL NAME [illegible]

4. [illegible] No [illegible] 214-61-1227

5. SEX [illegible]

6. COLOR OR RACE [illegible]

7. DATE OF BIRTH [illegible] July 20 - 941

8. AGE 57

9. BIRTHPLACE [illegible] Baltimore

10. USUAL OCCUPATION [illegible] Laborer

11. INDUSTRY OR BUSINESS [illegible] Not Given

12. NAME OF SURVIVING SPOUSE [illegible] Mrs. [illegible] Foley

13. NAME OF FATHER [illegible] and [illegible]

14. MAIDEN NAME OF MOTHER [illegible] Sadie Richardson

15. BIRTHPLACE OF MOTHER [illegible] and [illegible]

16. INFORMANT [illegible] Mrs Charles [illegible]
    Address 334 Mt Olivet Lane

17. BURIAL, CREMATION, REMOVAL [illegible] Burial
    Date thereof [illegible] 1 30 41
    Cemetery or crematory [illegible] Woodlawn Cem
    Location [illegible] Woodlawn Balto Co

18. FUNERAL DIRECTOR [illegible] [illegible] & Co
    Address [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

38. [illegible]

39. [illegible]

40. [illegible]

41. [illegible]

42. [illegible]

43. [illegible]

44. [illegible]

45. [illegible]

46. [illegible]

47. [illegible]

48. [illegible]

49. [illegible]

50. [illegible]

51. [illegible]

52. [illegible]

53. [illegible]

54. [illegible]

55. [illegible]

56. [illegible]

57. [illegible]

58. [illegible]

59. [illegible]

60. [illegible]

61. [illegible]

62. [illegible]

63. [illegible]

64. [illegible]

65. [illegible]

66. [illegible]

67. [illegible]

68. [illegible]

69. [illegible]

70. [illegible]

71. [illegible]

72. [illegible]

73. [illegible]

74. [illegible]

75. [illegible]

76. [illegible]

77. [illegible]

78. [illegible]

79. [illegible]

80. [illegible]

81. [illegible]

82. [illegible]

83. [illegible]

84. [illegible]

85. [illegible]

86. [illegible]

87. [illegible]

88. [illegible]

89. [illegible]

90. [illegible]

91. [illegible]

92. [illegible]

93. [illegible]

94. [illegible]

95. [illegible]

96. [illegible]

97. [illegible]

98. [illegible]

99. [illegible]

100. [illegible]

101. [illegible]

102. [illegible]

103. [illegible]

104. [illegible]

105. [illegible]

106. [illegible]

107. [illegible]

108. [illegible]

109. [illegible]

110. [illegible]

111. [illegible]

112. [illegible]

113. [illegible]

114. [illegible]

115. [illegible]

116. [illegible]

117. [illegible]

118. [illegible]

119. [illegible]

120. [illegible]

121. [illegible]

122. [illegible]

123. [illegible]

124. [illegible]

125. [illegible]

126. [illegible]

127. [illegible]

128. [illegible]

129. [illegible]

130. [illegible]

131. [illegible]

132. [illegible]

133. [illegible]

134. [illegible]

135. [illegible]

136. [illegible]

137. [illegible]

138. [illegible]

139. [illegible]

140. [illegible]

141. [illegible]

142. [illegible]

143. [illegible]

144. [illegible]

145. [illegible]

146. [illegible]

147. [illegible]

148. [illegible]

149. [illegible]

150. [illegible]

151. [illegible]

152. [illegible]

153. [illegible]

154. [illegible]

155. [illegible]

156. [illegible]

157. [illegible]

158. [illegible]

159. [illegible]

160. [illegible]

161. [illegible]

162. [illegible]

163. [illegible]

164. [illegible]

165. [illegible]

166. [illegible]

167. [illegible]

168. [illegible]

169. [illegible]

170. [illegible]

171. [illegible]

172. [illegible]

173. [illegible]

174. [illegible]

175. [illegible]

176. [illegible]

177. [illegible]

178. [illegible]

179. [illegible]

180. [illegible]

181. [illegible]

182. [illegible]

183. [illegible]

184. [illegible]

185. [illegible]

186. [illegible]

187. [illegible]

188. [illegible]

189. [illegible]

190. [illegible]

191. [illegible]

192. [illegible]

193. [illegible]

194. [illegible]

195. [illegible]

196. [illegible]

197. [illegible]

198. [illegible]

199. [illegible]

200. [illegible]

201. [illegible]

202. [illegible]

203. [illegible]

204. [illegible]

205. [illegible]

206. [illegible]

207. [illegible]

208. [illegible]

209. [illegible]

210. [illegible]

211. [illegible]

212. [illegible]

213. [illegible]

214. [illegible]

215. [illegible]

216. [illegible]

217. [illegible]

218. [illegible]

219. [illegible]

220. [illegible]

221. [illegible]

222. [illegible]

223. [illegible]

224. [illegible]

225. [illegible]

226. [illegible]

227. [illegible]

228. [illegible]

229. [illegible]

230. [illegible]

231. [illegible]

232. [illegible]

233. [illegible]

234. [illegible]

235. [illegible]

236. [illegible]

237. [illegible]

238. [illegible]

239. [illegible]

240. [illegible]

241. [illegible]

242. [illegible]

243. [illegible]

244. [illegible]

245. [illegible]

246. [illegible]

247. [illegible]

248. [illegible]

249. [illegible]

250. [illegible]

251. [illegible]

252. [illegible]

253. [illegible]

254. [illegible]

255. [illegible]

256. [illegible]

257. [illegible]

258. [illegible]

259. [illegible]

260. [illegible]

261. [illegible]

262. [illegible]

263. [illegible]

264. [illegible]

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address 2[illegible]
   c. Hospital or institution:
   d. Length of stay in hospital or inst. yrs. mos. or days
   e. Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
   a. State Md
   b. County
   c. City or town
   d. Street No.
   e. Citizen of foreign country? If yes, name country

3. FULL NAME MARGARET E. HILLE

3. If veteran, name war
3. Social Security Account No.

4. Sex Female
5. Color or race White
6. Single, married, widowed, or divorced

6. Name of husband or wife Jac[illegible] If alive, give age years

7. Birthdate of deceased mo. Nov 13 [illegible]

8. AGE: Years 79 Months 1 Days If less than one day hr. min.

9. Birthplace [illegible]

10. Usual Occupation at home

11. Industry or business

MOTHER / FATHER

12. Name [illegible]

13. Birthplace Ger

14. Maiden Name [illegible]

15. Birthplace Wash

16. Informant Geo a [illegible]
    Address [illegible]

17. [illegible] Date thereof
    Cemetery or crematory Ho[illegible]
    Location

18. Funeral director
    Address 20[illegible]

19. a. Date received by registrar

V= 15[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November [illegible] 1[illegible] M

21. I certify that I attended deceased from Aug 1[illegible] 1[illegible] 4[illegible] and that I last saw her alive on 11-[illegible]-4

Immediate cause of death Coronary Thrombosis. Duration 2 days

Due to Chronic myocard[illegible] with arteriosclerosis 4 yrs.

Due to Hypertension & arteriosclerosis

Other Conditions

Date of operation none

Major findings of operation:

of autopsy: none

22. If death was due to external causes (violence)
    a. Accident, suicide, or homicide
    b. Date of occurrence M
    Where did injury occur?
    c. Did injury occur at or in home, on farm, industrial place or public place?
    Means of injury

23. Signature Jacob M. Miller

Address 1613[illegible] Baltimore St 11/28/4[illegible]

PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the cause of death clearly and legibly.

1. PLACE OF DEATH
   a. Baltimore City, Maryland
   b. Street address 1743 Clarkson St
   c. Hospital or institution

   d. Length of stay in hospital or inst. yrs., mos., or days
   e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   State Md
   City or town Baltimore
   a. Street No. 1743 Clarkson St
   c. Citizen of foreign country?
   If yes, name country

3. FULL NAME Martin [illegible] Stumme

3a. If veteran, name war — Social Security No.

4. Sex: Male
5. Color or race: White
6. Single, married, widowed, or divorced: Married
   a. Name of husband or wife: Margaret Stumme
   b. If single, give age years

7. Birth date of deceased: mo. Sept day 5 yr 1884
8. AGE: Years 61 Months 2 Days 20 If less than one day: hr. min.
9. Birthplace: Baltimore (Town, county and state)
10. Usual Occupation: Bartender
11. Industry or business

MOTHER / FATHER

12. Name: Conrad Stumme
13. Birthplace: Germany
14. Maiden Name: Mary ?
15. Birthplace: Germany

16. Informant: Mrs Margaret Stumpe
    Address: 1743 Clarkson St

17. Burial — Date thereof: Nov 09-
    Cemetery or crematory: Oak Lawn
    Location: City

18. Funeral director: Leissa Funeral Home
    Address: 2008 Orleans St

19. NOV 22 1945
    Date received by registrar — Registrar

V5 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 2 [illegible] M

21. I certify that death occurred at [illegible] of deceased [illegible] and that I last saw h[illegible] alive on

	Duration
Immediate cause of death	
Due to	
Due to	
Other Conditions	

FBY JOAN

Date of operation
Major findings of operation

of autopsy:

22. If death was due to external causes (violence):
    a. Accident, suicide or homicide
    b. Date of occurrence
    c. Where did injury occur?
    d. Did injury occur about home, [illegible] place?
    e. Means of injury

23. Signature

Address

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age at last birthday is especially important. Physicians please write the causes of death clearly and legibly.

1 PLACE OF DEATH
a Baltimore City, Maryland
b Street address 1805 N Port St
c Hospital or institution

d Length of stay in hospital or inst. yrs., mos., or days
e Length of stay in Baltimore yrs., mos., or days Life

2 USUAL RESIDENCE OF DECEASED
a State Md. County Balto
City or town Baltimore
b Street No. 1805 N Port St
c Citizen of foreign country
If yes, name country

3 FULL NAME Mary E. Vermilt

3 a If veteran, name war
3 b Social Security Account No.

4 Sex Female 5 Color or race White 6 a Single, married, widowed or divorced Married

6 b Name of husband or wife Otto Vermilt
6 c If alive, give age years

7 Birth date of deceased mo. day yr. Sept 13 1854

8 AGE Years 62. Months Days
If less than one day hr min

9 Birthplace Baltimore
Town, county and state

10 Usual Occupation
11 Industry or business At home

MOTHER FATHER
12 Name Geo Murphy
13 Birthplace Ireland
14 Maiden Name Mary A Lee
15 Birthplace Ireland

16 a Informant Otto Vermilt
b Address 1805 N Port St

17 a Burial Date thereof
Burial, cremation, removal
b Cemetery or crematory Mt Olivet
Location Baltimore

18 a Funeral director Eckhardt Funeral Home
b Address 200 Park Ave

19 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20 DATE OF DEATH Sept 27 1916 at 2 A.M.

21 I certify that death occurred on the date above stated that I attended deceased from Nov. 1915 to Nov. 1916 and that I last saw her alive on Sept. 27 1916

Immediate cause of death — Duration
a Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

Operation — Duration

PHYSICIAN

Date of operation
Major findings of operation

of autopsy

22. If death was due to external causes fill in the following:
a Accident, suicide or homicide
b Date of occurrence M
Where did injury occur?
Did injury occur about home, in factory or other place?
c Means of injury

23. Signature

Address Date signed 11-2-

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully searched for and plainly written. Physicians please write the causes of death clearly and legibly.

1 PLACE OF DEATH
a Baltimore City, Maryland
b Street address 1813 W. Monroe St.
c Hospital or institution

d Length of stay in hospital or inst. yrs., mos., or days
e Length of stay in Baltimore yrs., mos., or days

2 USUAL RESIDENCE OF DECEASED
a State Md
b City or town Baltimore
c Street No. 1813 W. Monroe St.
d Citizen of what country
Race, white, negro, etc.

3 FULL NAME Mary Ellen Amon

3 a If veteran, name war
3 b Social Security Account No

4 Sex F.
5 Color or race W. (white, negro, Indian, etc.) single, married, widowed, or divorced

6 a Name of husband or wife Frank Amon
b If alive, give age years

7 Birth date of deceased mo., day, yr June.
8 AGE Years 76 Months Days If less than one day hr min

9 Birthplace Baltimore
Town, County, and State

10 Usual Occupation Housewife
11 Industry or business

MOTHER FATHER
12 Name John Lordon
13 Birthplace Ireland
14 Maiden Name Mary Ellen Lordon
15 Birthplace Ireland

16 Informant Mrs. Elizabeth Drumm
a Address 1813 W. North Ave.

17 Burial Date thereof 11/30/48
Cemetery or crematory Cathedral
Location Baltimore

18 Funeral director MARTIN FAHEY & SONS
Address 1827 W. NORTH AVE.

19 Date received by registrar Registrar

V. S. 150

MEDICAL CERTIFICATION

20 DATE OF DEATH Nov. 26 1948 at 6:35 P.M.

21 I certify that death occurred on the date above stated, at the hour of decease as above, and that I last saw deceased alive on 11/26/48

Immediate cause of death
a Coronary Thrombosis
Duration 1 yr.
Due to
b
Due to
c
Other Conditions

Date of operation
Major findings of operation

Did autopsy confirm diagnosis?

22 If death was due to external causes, fill in the following:
a Accident, suicide or homicide
b Date of occurrence M
c Where did injury occur?
d Did injury occur while at work? (Yes or no)
e How did injury occur? (Specify whether in motor vehicle accident, industrial accident, home accident, or other accident; if in public place, specify.)
f Means of injury

23 Signature
Address Date signed

PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No

1 PLACE OF DEATH

Baltimore City, Maryland

2 USUAL RESIDENCE OF DECEASED

FULL NAME

Cardiac failure — 3 weeks

arteriosclerotic heart disease — ?

Emphysema and chronic atheromatic disease — ?

MOTHER / FATHER

Horseshoe kidney

Signature: David H Marine

Balto City Hospo

11-26-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1 PLACE OF DEATH
Baltimore City, Maryland

a Street address
b Hospital or Institution

c If death occurred in hospital or institution, give ward or room number

d If death was in Baltimore City, name of attending physician

2 USUAL RESIDENCE OF DECEASED

a State

b City or town

c Ward

d Street address

e Length of stay at present address

f Length of stay in Baltimore City

3 FULL NAME

4 Sex

5 Color or race

6 Single, married, widowed, or divorced

7 Date of birth

8 Age

9 Birthplace

10 Usual occupation

11 Industry or business

MOTHER'S FATHER

12 Name

13 Birthplace

14 Maiden name

15 Birthplace

16 Informant

Address

17 Date of death

18 Date of interment

Cemetery or crematory

Location

19 Funeral director

Address

Signature

20 Address

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1 PLACE OF DEATH

Baltimore City, Maryland

Street address

Hospital or institution

Length of stay in Baltimore City, Md., if not a resident

2 USUAL RESIDENCE OF DECEASED

Street address

Length of stay in Baltimore City, Md., if not a resident

3 FULL NAME

WIDOWED

WM [illegible] ARBAUGH

OCT 7 1925

4 DATE OF DEATH

20 1 10

5 AGE

WESTMINSTER CARROLL MD

6 BIRTHPLACE

HOUSE WORK

7 OCCUPATION

SAMUEL WILHIDE

CARROLL COUNTY MD

8 NAME OF FATHER

LYDIA MILLER

CARROLL COUNTY MD

9 MAIDEN NAME OF MOTHER

MRS ROGER LINDSAY

10 RESIDENCE

LIBERTY ST. WESTMINSTER MD

11 BURIAL

DEC 1 1925

12 CREMATION

13 PLACE OF BURIAL OR REMOVAL

WESTMINSTER CEMETERY

14 UNDERTAKER

WESTMINSTER MD

15 ADDRESS

J. FRANCIS REESE

16 SIGNATURE

WESTMINSTER MD

17 DATE SIGNED

Signature

Address

Date signed

M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly

1. **PLACE OF DEATH:**
   a. Baltimore City, Maryland
   Street address 310 Harlem Ave.
   Hospital or institution

2. **USUAL RESIDENCE OF DECEASED**
   State Md.
   City or town Baltimore
   Street No. 310 Harlem Ave.
   Citizen of foreign country? NO
   If yes, name country

d. Length of stay in hospital or inst. yrs., mos., or days
e. Length of stay in Baltimore yrs. mos. or days Life

3. a. **FULL NAME** Minnie M. Jerrett

b. If veteran, name war No

c. Social Security Account No. No

4. Sex F M

5. Color or race White

c. Single, married, widowed, or divorced Widowed

6. b. Name of husband or wife William Jerrett

b. If alive, give age years

7. Birth date of deceased mo. day, yr. May 15, 1868

8. **AGE:** Years 80 Months 6 Days 15 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Home

11. Industry or business "

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden Name "

15. Birthplace "

16. a. Informant Mrs. Label Black

b. Address 310 Harlem Ave.

17. Burial Date Buried 11/30/48

Cemetery or crematory Westminister

Location Westminister, Maryland

18. Funeral director John T. Stansbury

2700 Edmondson Ave.

19. NOV 30 1948 Tentative Interment

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** at M

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw h alive on

Immediate cause of death — Duration

Due to

Due to

Other Conditions

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

22. If death was due to external causes, fill in the following:

a. Accident, suicide, or homicide

b. Date of occurrence M

Where did injury occur?

Did injury occur in or about home, on farm, in industrial place? Specify

Means of injury

Signature

Address

6689.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

6689.7
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Tissure St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEL SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1871

8. AGE: Years	Months	Days	If less than one day
77 yrs.	1	3	hr. min.

9. Birthplace Salem, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Manuel Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice ?
15. Birthplace Maryland

16 (a) Informant: William D. Scott
(b) Address 408 George Street

17 (a) Burial (b) Date thereof 11/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible] Cemetery
Location Mt. [illegible]

18 (a) Funeral director Adolphus Hallstead
(b) Address 918 Druid Hill Avenue

19 (a) NOV 29 1948 (b) Farmington Williams, M.D.
(Date rec'd by registrar) (Signature)

VS 15t

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner

Date signed 11-26-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6689 68

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1002

Registered No. 6689 68

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Black

3 (b) If veteran, name war

3 (c) Social Security Account No. unknown

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: W. Colored

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) unknown

8. AGE: Years 72 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Rev Holland Brown
(b) Address 1015 - Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director A. Hulsteyn
(b) Address 918 Druid Hill Ave.

19 (a) NOV 29 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 23 | 1948, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 | 20 | 1948 to 11 | 23 | 1948 and that I last saw h[illegible] alive on 11 | 23 | 1948.

Immediate cause of death Congestive Heart failure — Duration

Due to Pulmonary infarction

Due to Thrombo-phlebitis of femoral vein

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Brady M. D.
Address 1514 - Division St Date signed 11/24/48

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6689 69

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 6689 69

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. CAREY Street
(c) Hospital or institution: 18 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. CAREY Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie MARIE Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	16	hr. min.

9. Birthplace King William County, VA. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace King William County, VA.

MOTHER 14. Maiden Name ELLA Stewart

15. Birthplace King William County, VA.

16 (a) Informant Annie Hill

(b) Address 4911 Reno st; Philadelphia, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Balto Co

18 (a) Funeral director Wm A Jackson

(b) Address 916 Pedmont Ave Fairmont West Virginia

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948, at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28, 1948. to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

Immediate cause of death	Duration
CARDIAC Failure	2 Days
Due to Cerebral Hemorrhage	Month
Due to Hypertensive Heart Disease	Several Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 E. Franklin St. Date signed 11-29-48

VS 150

6897C

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 6897C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joshua Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Emmaline
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1884

8. AGE: Years	Months	Days	If less than one day
64	9	28	hr. min.

9. Birthplace Bengies, Maryland (Town, county, and state)
10. Usual Occupation Railroad Worker
11. Industry or business Unknown

FATHER
12. Name "
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Cooper
(b) Address 1524 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day)
(c) Cemetery or crematory
Location Edgely Md

18 (a) Funeral director Gray Wilson
(b) Address 1000 Brentley ave

19 (a) NOV 29 1945 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1945 at 3:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Auricular Fibrillation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. McFadden M.D. Medical Examiner
Date signed 11-26-45

68971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS TERESA ENGLAND

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Wm. L. England
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr) JAN 7, 1878

8. AGE: Years 70 | Months 10 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name John Koenig
13. Birthplace Germany

MOTHER 14. Maiden Name Francis Fisher
15. Birthplace Balto. Md. U.S.A.

16 (a) Informant Wm. L. England
(b) Address 4001 Glenmore Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lazarahn Funeral Home
(b) Address 7101 Belair Rd.

NOV 29 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1948 to Nov 28 1948 and that I last saw her alive on Nov 28 1948.

Immediate cause of death	Duration
Cardiovascular failure	
Due to Cerebrosclerotic C-V Disease	?
Due to	
Other Conditions Partial rectal obstruction (cause?), Uterine (Include pregnancy within 3 months of death)	
Date of operation None	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Burnett M. Snelson M.D.
Address Mercy Hosp. Date signed 11/28/48

VS 150

G68972 C-48-284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

✓ Registered No. G68972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 McAleer Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Alden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 26, 1948

8. AGE: Years	Months	Days	If less than one day
		4	3 hr. 55 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Frederick Alden
13. Birthplace

MOTHER
14. Maiden Name Dorothy Loretta Myers
15 Birthplace Baltimore, Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director D. Ruck
(b) Address 5305 Harford Rd

19 NOV 29 1948 (Date received by Registrar) (b) Burying or Cremation Permit No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1948 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21/ 1948 to 11/26/ 1948, and that I last saw him alive on 11/26/ 1948

Immediate cause of death	Duration
Respiratory failure	5 min.
Due to aspiration of mucous?	?
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature James S. Hartke M. D.
Address St. Joseph Date signed 11-26-48

68973 ✓ 68973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Columbia, S.A.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Medellin
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country South America

3 (a) FULL NAME Antonio Arrango

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Angelo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-28-96

8. AGE: Years 52 | Months 3 | Days 21 | If less than one day hr. min. 29

9. Birthplace South America (Town, county, and state)

10. Usual Occupation Real Estate Broker

11. Industry or business

FATHER 12. Name Pablo Arrango

13. Birthplace S.A.

MOTHER 14. Maiden Name Rosa Ochoa

15. Birthplace S.A.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory Medellin

Location Colombia S.A.

18 (a) Funeral director Wm Cook Inc.

(b) Address 212 St Paul St

19 (a) (b)

(Date received by registrar) NOV. 29 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1948, to 11-27-1948, and that I last saw him alive on 11-27-1948

Immediate cause of death
(1) Congestion of superior renal vein

Due to (2) Carcinoma, metastatic, ? hypernephroid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman E. Shamer, MD M. D.

Address Johns Hopkins Hospital Date signed 11-27-48

X

668974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

668974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: Bar Wil-Be Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Low Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a). FULL NAME Robert Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Unk.

11. Industry or business

FATHER 12. Name Robert Miller, Sr.
FATHER 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Unk.
MOTHER 15. Birthplace Unk.

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location Anne Arundel County, Md.

18 (a) Funeral director Joseph A. Sidney
(b) Address 66 West Baltimore Street

19 Nov 29 1948 (b) [illegible] Baltimore Md.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25th 1948 at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30-1948 to 11-25-1948, and that I last saw h- alive on 11-24-1948.

Immediate cause of death Cardio Vascular Renal Disease - 1 yr. Prostatic hypertrophy

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert L. Jackson M.D.
Address 600 N. Arlington Ave. Date signed 11-27-48

668975

LCH - 124543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

668975
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Poppleton Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RACHAEL FERNANDEZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/12/1901

8. AGE: Years	Months	Days	If less than one day
47	10	13	hr min

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Smith (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabel Brown
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Retta R. Williams
(b) Address 322 N. Schroeder St

19 NOV 29 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/48 19 at 3:00 AM M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/13/48 19 to 11/25/48 19 and that I last saw her alive on 11/25/48 19

Immediate cause of death
CARDIAC FAILURE — Duration ?

Due to
HYPERTENSIVE HEART DISEASE — ?

Due to

Other Conditions
SYRINGOMYELIA
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T Rowan P. Gerwig Jr. M.D.
Address BALTIMORE CITY HOSP. Date signed 11-25-48

939

668976 C- 48-21272 668976

A16695 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 LENNOX, ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL FRANK MORGAN

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife: --
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 4-22-48

8. AGE:

Years	Months	Days	If less than one day: hr.	min.
	7	5		

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles Morgan
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 27 1948 at 3A 15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-26-1948 to 11-28-1948 and that I last saw him alive on 11-27-1948.

Immediate cause of death	Duration
Cortical damage	
Due to hyperpyrexia	
Due to	
Other Conditions (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: Cardiac Failure Cardiac Enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Ryan
Address Johns Hopkins Hosp. Date signed 11/28/48

VS 130

668977

AB-59494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

668977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Lewis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Florence Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Edward (D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 19-? 75

8. AGE: Years	Months	Days	if less than one day
73?	1	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joshua Turner (D
13. Birthplace Md.

MOTHER
14. Maiden Name Jane ? (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29th 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md.

18 (a) Funeral director Byron & Morris W. Knight
(b) Address 727 Edgecombe St

NOV 29 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 6.40P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-25- 19 40 to 11-24- 19 48 and that I last saw her alive on 11-24- 19 48

Immediate cause of death BRONCHOPNEUMONIA — Duration 10 DAYS

Due to BRONCHIECTASIS — .?

Due to

Other Conditions NEPHROSCLEROSIS. PURULENT PERICARDITIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address BALTIMORE CITY HOSP. Date signed 11-25-48

VS 159

107

G68978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G68978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Dukeland Ave

(c) Hospital or institution: West Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 620 Dumbarton Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mary A. Roycroft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Raymond R Roycroft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1874

8. AGE: Years 54 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Murray

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kilmartin

15. Birthplace Ireland

16 (a) Informant Raymond Roycroft

(b) Address 620 Dumbarton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)

(c) Cemetery or crematory New Catholic

Location Old Frederick Rd

18 (a) Funeral director John A Moran

(b) Address 3000 E Baltimore St

19 (a) [illegible] 19[illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/48 19 to 11/27/48 19, and that I last saw her alive on 11/27 19 48

Immediate cause of death Liver failure

Due to cirrhosis?

Due to metastatic carcinoma?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature J P Young M. D.

Address W.B.G. Hospital Date signed 11/27/48

SANDS

668979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 668979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway at Fremont

(c) Hospital or institution: Church Home and Hospital 11 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 706 Park Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Miss ~~Linda~~ Sands (Laydia)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: Unknown

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1879

8. AGE: Years 69 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name August Sands

13. Birthplace unknown

MOTHER 14. Maiden Name Nancy ?

15. Birthplace unknown

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30th 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo J. Cook

(b) Address 2203 N. Patterson Park ave

19 (a) Nov 29 1948 Huntington Williams, M.D.

(Date rec'd by registrar) WORLD WAR II VETERAN

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948, at 7:35 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/28 (23) 1948 to 11/28 1948 and that I last saw her alive on 11/28 1948.

Immediate cause of death Pulmonary Edema

Dilatation of Heart

Hypertrophy of Heart

Due to Arteriosclerotic Heart Disease 10 yrs

Due to

Other Conditions Asthma pneumonia

Left Lower lobe, Org. ~~Lung~~ Lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirms above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lee M. Howard M. D.

Address Church Hospital Date signed 11/29/48

VS 150

9-D

668980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

668980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Fourteen + Hunt
(c) Hospital or institution: Univ Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 W. FAYETTE St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse M Gilbert

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. MAY 1- 1879

8. AGE: Years 69 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles M. Scott
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Preston
15. Birthplace Balto, Md

16 (a) Informant Dorothy V. Thompson
(b) Address 1325 W. FAYETTE St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1-1948 (month) (day) (year)

(c) Cemetery or crematory MEADOWRIDGE CEM
Location Ellicott City Md

18 (a) Funeral director Robt C & B M. Waters
(b) Address Robt. Stricker Sr

19 (a) (Date received by registrar) NOV 30 1948 Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 (Month) (Day) 48 (Year) at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 19 48 to Nov 28 1948 and that I last saw h[illegible] alive on Nov 28 1948.

Immediate cause of death	Duration
Peripheral circulatory collapse	8 hours
Due to Meningoencephalomyelitis study undetermined	3 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Thein

Address Univ Hospital Date signed 11/28 M. D.

G68981 ✓ G68981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 230 South Stricker St. (If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) FULL NAME Charles F. Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 2/27/78

8. AGE: Years	Months	Days	If less than one day
70	9	2	— hr. — min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER	12. Name	John F. Hall
	13. Birthplace	Virginia
MOTHER	14. Maiden Name	Kat Knauer
	15. Birthplace	Virginia

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4-1948 (month) (day) (year)

(c) Cemetery or crematory

Location Mathews Virginia

18 (a) Funeral director Pott & B.M. Walker

(b) Address Pratt & Smith Sts

19 (a) Nov 2 1948 (b) Signature of local registrar Cuthbert Williams M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948, at 6 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1948, to 11/27 1948

and that I last saw him alive on 11/27 1948.

Immediate cause of death Cardiac failure

Due to Arterio Sclerosis

Heart disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 11/29/48

Major findings of operation: Cardiac

Also probably malignant

Contributes Post death

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Maynard R Ramsey M.D.

Address 7 West 39th St Date signed 11/29/48

668982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 668982 Registered No. 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-1
(c) Hospital or institution: Mercy Hospital Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 68

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) Baltimore
(d) Street No. 4020 Willsby Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. AGNES M. O'DONNELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married.

6 (b) Name of husband or wife Charles R O'Donnell.
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 10, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	19	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Peter Williams
13. Birthplace Austria

MOTHER
14. Maiden Name Christine Muller
15. Birthplace Germany

16 (a) Informant: Charles R. O'Donnell
(b) Address 4020 Willsby Ave. Balto 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director H. H. Weaver and Son
(b) Address 805 N. Calvert St.

19 NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1948, to Nov 27 1948 and that I last saw h[illegible] alive on Nov 27 1948

Immediate cause of death Cardio-Vascular Collapse — Duration

Due to Arteriosclerotic C.V. Renal

Due to Generalized Cachexia

Other Conditions Uremia; Intestinal Obstruction; Carcinoma of large Bowel

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rupert M. Omelee, M.D.
Address Mercy Hospital Date signed 11/27/48

92D

VS 150

G68983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 46 B

Registered No. G68983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LABOR RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Freeman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-4
(e) Length of stay in Baltimore (yrs., mos., or days) About 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Freeman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Marie [redacted] Lampe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Peter Lampe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1849

8. AGE: Years 99 | Months 5 4 | Days 10 | If less than one day hr. min.

9. Birthplace Copenhagen, Denmark (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name ? Anderson
13. Birthplace Denmark

MOTHER
14. Maiden Name ? ? Caughley
15. Birthplace Denmark

16 (a) Informant Mrs. Ida F. Lampe
(b) Address 603 Freeman St. Balto 25 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1948 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.
Location Balto Md.

18 (a) Funeral director C. Howard Thomas
(b) Address 2005 Charles St Balto 30 Md.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon., Nov 26, 1948, at 9.55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Nov 1948 and that I last saw her alive on Nov 26 1948

Immediate cause of death: Ulcerated carcinoma

Duration

Due to primary cancer stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Kuntz, M.D.

Address 3021 Patapsco Ave Date signed 11/28/48

668984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

668984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 + 3
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balte (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Laurens St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Louise Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation
11. Industry or business House wife

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Robert Smith
(b) Address 410 Laurens St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Guilford Ave
Huntington Williams, Md

19 (a) (Date rec'd by registrar) NOV 29 1948 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Nov 27 1948 and that I last saw her alive on Nov 27 1948.

Immediate cause of death Carcinoma of Uterus — Duration Months Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State) —
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Garland Thomas M. D.
Address 1354 Druid Hill Ave Date signed Nov 30, 1948

G68985 ✓ G68985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDDIE ENTZMINGER

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. —

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Augusta Entminger
13. Birthplace South Carolina

MOTHER
14. Maiden Name Easter ?
15. Birthplace South Carolina

16 (a) Informant Hattie Diles
(b) Address 1730 Wood St., Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-48 (month) (day) (year)
(c) Cemetery or crematory Balto nat'l
Location md

18 (a) Funeral director George B. Kelton
(b) Address 1303 Presstman ST

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1948, at 4.05a M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Contusion of spinal cord.

Due to Fracture of neck.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-23-48 at approx. 2.30 p. M.
(b) Where did injury occur? Old Court Rd. Pikesville
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Fell off haywagon to street

23. Signature Thos G. Merrill M.D. (Medical Examiner.)
Date signed November 20, 1948

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

668986 Registered No. 668986

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Barclay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgene Lloyd Henderson

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife William Henderson
6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr) Aug 27 1899

8. AGE: Years 49 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Lloyd
13. Birthplace Md

MOTHER 14. Maiden Name Emma Gray
15. Birthplace Md

16 (a) Informant Charles Lloyd
(b) Address 3407 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm Francis A Kunsler
(b) Address 578 W Biddle St.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1948, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24th 1948 to Nov. 26th. 1948. and that I last saw her alive on Nov. 24th. 1948.

Immediate cause of death: Carcinoma of the Stomach — Duration: about 6 mos

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno W Hungerford MD
Address 401 E. 25th. St. Date signed 11/27/48.

VS 150

G68987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G68987

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 769 Sarah Ann Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 769 Sarah Ann St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA M. HOLLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 25 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min
45	2	3		

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Natheria Sykes

13. Birthplace N. C.

MOTHER

14. Maiden Name Annie Wilson

15. Birthplace N. C.

16 (a) Informant Mrs Virginia Hollis

(b) Address 769 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1,1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery Cem.

Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 573 W. Biddle St.

DEC 29 1948 (a) (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 27, 1948, at 12:45

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1948 to 11/27 1948. and that I last saw Deceased alive on 11/22 1948

Immediate cause of death: Cerebral vascular hemorrhage — Duration 2 days

Due to

Due to Hypertension ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Carnes

Address 253 George St Date signed 12/29/48 M. D.

VS 150

G68988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G68988
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's Co.
(c) City or town Baldwin (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Co. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Fenwick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1928

8. AGE: Years	Months	Days	If less than one day: hr.	min
20	5	10		

9. Birthplace St. Mary's Co. Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Fenwick
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Edna Smith
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Christine Fenwick
(b) Address St. Mary's Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory Valley Lee Cem.
Location St. Mary's Co. Md.

18 (a) Funeral director Vivo B. Pettingill
(b) Address Leonardtown Md.

19 (a) (Date received) (b) (Registrar)

NOV 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948 at 1:04 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-24 1948 to 11-27 1948 and that I last saw her alive on 11-27 1948.

Immediate cause of death Respiratory failure

Due to Menings - encephalitis probable Tuberculosis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Highlower
Address Univ. Hosp. Date signed 11-29-48 (M. D.)

668989

BALTIMORE CITY HEALTH DEPARTMENT ✓ V668989

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Anna B. Loewer

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Henry G. Loewer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	10	hr. min.

9. Birthplace New York State (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Baumgartner
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Kreiger
15. Birthplace Germany

16 (a) Informant Mr. Henry G. Loewer
(b) Address 14841 Elderwood, E. Cleveland, Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 November 1948 at 6 48 M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 Nov 1948 to 26 Nov 1948, and that I last saw h[illegible] alive on 26 Nov 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Cerand M. D.

Address Date signed

E. A. Cerand

66890 ✓ 66890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 3708 Brooklyn Ave.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walter Tillery
3 (b) If veteran, name war: none
3 (c) Social Security Account No. 217-03-0590.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Elsie M. Tillery
6 (c) If alive, give age: years

7. Birth date of deceased: mo., day, yr. Jan. 12, 1877

8. AGE: Years	Months	Days	If less than one day
71	10	15	hr. min.

9. Birthplace: Middlesex Co., Va. (Town, county, and state)
10. Usual Occupation: Stevedore
11. Industry or business

FATHER
12. Name: John Tillery
13. Birthplace: Va.

MOTHER
14. Maiden Name: Eliza Dulaney
15. Birthplace: Ft. McHenry

16 (a) Informant: Mrs. Elsie M. Tillery
(b) Address: 3708 Brooklyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (Huntington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-48 10 2.55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948 to 11-27 1948, and that I last saw him alive on 11-27 1948

Immediate cause of death: Carcinoma of esophagus
Due to:
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

7 Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Charles B. MacDonald M.D.
Address: 1213 Eight St. Date signed: 11-27-48

VS 150

68991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

952

68991

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3909 Bonner Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3909 Bonner Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: BLANCHE M. JOHNSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Eugene D. Johnson

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1877

8. AGE: Years: 71 | Months: 9 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER

12. Name: Edward J. Piquett

13. Birthplace: U. S. A.

MOTHER

14. Maiden Name: Amanda Stansbury

15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mr. William A. Piquett

(b) Address: 2722 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27, 1948, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Nov 27 1948. and that I last saw h-e alive on Nov 7 1948

Immediate cause of death	Duration
Coronary occlusion from thrombosis about 10 min	
Due to Cardiovascular disease	5 Mo
Due to arterio-sclerosis	?
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter D. Hulbert M. D.

Address 2220 Garrison Blvd Date signed NOV. 29/48

VS 153

668992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 668992 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Keyworth Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Keyworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS AUGUST STROHM, Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-05-7593

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daisy A. Strohm (nee Utterbaugh) 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept. 13, 1881

8. AGE: Years 67 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Horn Stevens Co.

FATHER
12. Name Thomas A. Strohm
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Md.

16 (a) Informant Mrs. Daisy A. Strohm
(b) Address 2812 Keyworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 5:20a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 3 1945 to Nov 28 1948. and that I last saw h im alive on Nov 20 1948.

Immediate cause of death	Duration
Cardiac failure —	suddenly
Due to Cardio Vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Bauman and Hood, M. D.
Address 2200 Garrison Blvd Date signed 11/29/48

VS 153

X

G68993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

✓ G68993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or ~~XXXXXXX~~ St. Joseph's 7-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 624 N. Collington Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hellman, Edgar Arthur

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	3	26 27		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Schreiber Bro.

FATHER 12. Name Henry J. Hellmann

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Caroline Louise Blaney

15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Irene M. Sessions

(b) Address 130 Oaklee Village

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Mausoleum

Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 12:00 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1948, to Nov. 27, 1948, and that I last saw him alive on Nov. 27, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Acute lymphatic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation November 15, 1948

Major findings of operation: Ischio-rectal abscess

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?

(e) Means of injury

23. Signature J. Joseph Krajci, M.D.

Address 1400 N. Caroline St. Date signed 11-27-48

VS 150

X

68994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 68994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert streets

(c) Hospital or institution: Union Memorial Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 827 Northern Parkway, Baltimore 2 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mildred A. Bradley Habercam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John H. Habercam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1902

8. AGE: Years	Months	Days	If less than one day
45	11	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11 Industry or business

FATHER

12. Name Albert C. Bradley

13. Birthplace Maryland

MOTHER

14. Maiden Name Geneviere Gill

15 Birthplace Maryland

16 (a) Informant Union Memorial Hospital records

(b) Address 33rd Street, Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Balto., Md.

Location

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

NOV 29 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948. to Nov. 26 1948, and that I last saw h er alive on Nov. 26 1948.

Immediate cause of death	Duration
Carcinoma, rt. Breast	
Due to: mets	
Due to	
Other Conditions multiple thrombi	
L. auricle	

(Include pregnancy within 3 months of death)

Date of operation Nov. 18, 1948

Major findings of operation: Carcinoma right breast with L. axillary metastases

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles N. Watt, J. M. D.

Address Union Memorial Hospital Baltimore 18, Md. Date signed 11/27/48

X

VS 1%

BC-48-25910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G68995

Registered No. G68995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Eager Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Stillborn

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4010 Maine Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl LeRoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/26/48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 30 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Melvin E. LeRoy

13. Birthplace Philadelphia Pa.

MOTHER

14. Maiden Name Mary D. Sutecki

15 Birthplace Maryburg, Wis.

16 (a) Informant Hosp. Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location City

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount & 20th

19 11-29-1948 Huntington Williams M.D.

(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 2:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/26/ 1948 to 11/27 1948, and that I last saw her alive on Nov. 27 1948.

Immediate cause of death: Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?

(e) Means of injury

23. Signature T. Sewinski

Address Mercy Hosp. Date signed 11/28/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 668996

668996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 McKewin Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 McKewin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Harrison Guade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian V. Guade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 24, 1890

8. AGE: Years	Months	Days	If less than one day
58	10	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Motion Picture

FATHER
12. Name Alex Guade
13. Birthplace Maryland

MOTHER
14. Maiden Name Madora Dean
15 Birthplace Maryland

16 (a) Informant Mrs Lillian V. Guade
(b) Address 611 McKewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John G. Morap
(b) Address 3600 E. Balt. St.

19 NOV 29 1948 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov. 1948 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 27 Nov. 1948 and that I last saw him alive on 26 Nov. 1948.

Immediate cause of death Adenocarcinoma of Stomach — Duration 8 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Aug. 20, 1948
Major findings of operation: Pyloric obstruction due carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature Wm. H. Kammerer M.D.
Address 501 Sheridan Ave. Date signed 29 Nov. 48

VS 150

X

G68997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G68997
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3526 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Grant Michael.

3 (b) If veteran, name war ———

3 (c) Social Security Account No. 217-12-2824

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Widowed.

6 (b) Name of husband or wife Mary L. Michael.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1864

8. AGE: Years	Months	Days	If less than one day
84	-	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Stationary Engineer.
11. Industry or business Western Maryland Dairy

FATHER
12. Name George W. Michael.
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Coleman.
15. Birthplace Md.

16 (a) Informant Mrs Blanche Mayes.
(b) Address 3526 Roland Ave.

17 (a) Burial. (b) Date thereof Nov. 30, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Cheatnut Ave.

(a) NOV 29 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1948 to Nov 23 1948 and that I last saw him alive on Nov. 23 1948

Immediate cause of death	Duration
Hypertensive Heart disease	?
Due to Arterio Sclerosis	?
Due to	
Other Conditions Marked cardiac Hypertrophy	?

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl A. Rostling M. D.
Address 1326 W Lombard Date signed 11/27/48

G68998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G68998 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Caroline Sts

(c) Hospital or institution: Franklin Square Hosp. 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 W 36th St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Georgeanna Reisinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Henry B Reisinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 7, 1869

8. AGE: Years 79 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER 12. Name Bartholomew McCubbin

13. Birthplace Md.

MOTHER 14. Maiden Name Rachel Blanchard

15. Birthplace Pa.

16 (a) Informant Chas J Reisinger

(b) Address 717 W-36 St. (Son)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location York Pa

18 (a) Funeral director Shumaker Funeral Home

(b) Address 215-17 Chestnut Ave

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Thomas Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1948, at 7 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1948. to 11/29 1948. and that I last saw her alive on 11/27 1948.

Immediate cause of death Cerebral Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Jones M. D.

Address Franklin Square Hosp. Signed 11-29-48

VS 130

G68999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2729 N. CALVERT
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 N. CALVERT ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NANNIE HOPKINS MORTON
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife THEODORE J. MORTON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) OCT. 27, 1860

8. AGE: Years	Months	Days	If less than one day hr.	min.
88	1	0		

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER 12. Name JOSEPH HOPKINS
13. Birthplace MARYLAND

MOTHER 14. Maiden Name NANNIE RYAN
15. Birthplace VIRGINIA

16 (a) Informant CHARLES C. MORTON
(b) Address 2729 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 30 '48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTO., MD.

18 (a) Funeral director HENRY W. JENKINS & SON
(b) Address 4905 YORK RD.

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form 2 NOV 29 1948 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1948 at 10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 24 1948 to Nov. 27, 1948. and that I last saw her alive on Nov. 27 1948

Immediate cause of death Myocardial Failure — Duration 3 days
Due to Chronic Myocarditis — months.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation none
Maior findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frank N. Ogden M. D.
Address 2701 N. Calvert St. Date signed Nov. 29, 48.

G65000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G65000

Every item of information should be carefully supplied. Please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Wilmington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter A. Hyson.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-8751

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M. W.

6 (b) Name of husband or wife Anna Heyson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April-16-1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	7	10		

9. Birthplace Baltimore md (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired.

MOTHER | FATHER
12. Name Frederick Thyson
13. Birthplace md Dead
14. Maiden Name Anna Elm
15. Birthplace md Dead

16 (a) Informant Son.
(b) Address 1024 Wilmington Ave.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore md
18 (a) Funeral director J. Nugent + Son
(b) Address 865 W. Baltimore St

19 (a) 12-1-1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1948 at 4:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-20- 1948, to 11-26 1948, and that I last saw him alive on 11-25 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic C-V-Disease	
Due to Coronary Insufficiency	

Other Conditions (include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Edsel G. Robinson M. D.
Address St. Agnes Hospital Date signed 12-1-48

G-69000 72

G-69000½

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G-69000½

CERTIFICATE OF DEATH 157E

B.C. 48-28847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 5-2
(d) Street No. 1112 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Cook

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Provident Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1948. at 8 55 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/17 1948. to 11/19 1948. and that I last saw him alive on 11/19 1948.

Immediate cause of death Cardiac Insufficiency — Duration

Due to 3 Chamber Heart

Due to Dextrocardia
Absence of anus

Other Conditions Intestinal Obstruction
Meckels Diverticulum
(Include pregnancy within 3 months of death)

Date of operation 11/18/48

Major findings of operation: Absence of anus
Intestinal obstruction Meckels Diverticulum
of autopsy: 3 chamber Heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature Dr Marcus N. Moore M.D.
Address Provident Hospital Date signed 3/30/49

G69001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G69001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2300 PENNA~~ 410
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9YRS, 6MOS, 27DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 POPLAR GROVE ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. FLORENCE E. ENEY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 27, 1859

8. AGE: Years 89 | Months 1 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name WILLIAM MALLONEE
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name CAMELA ROBINSON
15. Birthplace MARYLAND

16 (a) Informant NELLIE V. ENEY - DAUGHTER
(b) Address 410 POPLAR GROVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo. E. Boyd & Son
(b) Address 1512 Hollins St.

19 (a) ____ (b) ____ (Signature of registrar)

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 NOVEMBER 1948, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 01 OCT 1948 to 25 NOV 1948, and that I last saw HER alive on 25 NOV 1948.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	15 hours
Due to CEREBRAL HEMORRHAGE	9YRS
Due to HYPERTENSIVE CARDIO VASCULAR DISEASE	18YRS
Other Conditions GENERALIZED ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation:
of autopsy: NONE

PHYSICIAN: Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald J. England M. D.
Address Maryland Gen. Hosp. Date signed 25 Nov 48

VS 150

669002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669002

82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5941 Falls Road

(c) Hospital or institution:

27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5941 Falls Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. Bryan, Sr.

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-22-7974

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Josephine Bryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1876

8. AGE: Years 72 | Months 1 | Days 14 | If less than one day: hr. min

9. Birthplace: Baltimore Co., Maryland (Town, county, and state)

10. Usual Occupation: Overseer

11. Industry or business: Mrs. M. A. Long

FATHER

12. Name: Edgar Bryan

13. Birthplace: Maryland

MOTHER

14. Maiden Name: Emma A. Hook

15. Birthplace: Maryland

16 (a) Informant: Ebert J. Bryan

(b) Address: 1312 Asbury Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

18 (a) Funeral director: Burgee Funeral Home

(b) Address: 3631 Falls Road

19 (a) Date rec'd by registrar NOV 29 1948 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH November 29, 1948, at 7.15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1932 to 11-29 1948.

and that I last saw h[illegible] alive on 11-27 1948.

Immediate cause of death: Hypertension / CEREBRAL HEMORRHAGE — Duration: 2 yrs ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work

(Specify type of place)

(e) Means of injury

23. Signature H. O. Hardman M.D. M D

Address East Read St Date signed 11-29-48

669003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

669003 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Keswick Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sarah E. Hampshire

3 (b) If veteran, name war —
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. Hampshire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min
85	4	18		

9. Birthplace Baltimore Co., Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Nelson Price
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth --
15. Birthplace Maryland

16 (a) Informant John H. Hampshire
(b) Address 702 W. Joppa Road, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Grace Methodist
Location Black Rock Road, Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 19[illegible] Huntington Williams, M.D. Registrar
(b) (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 7 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 8 1948 to Nov. 27 1948, and that I last saw her alive on Nov 27 1948

Immediate cause of death: Myocardial insufficiency
Due to: Arteriosclerosis
Due to: Cardiac disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. Smith. M.D.
Address 342 Chestnut St. Date signed 11/29/48

VS 150

G65904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-D

G65904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 North Spring Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRYMAS KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1885

8. AGE: Years 63 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Steel Mill

FATHER
12. Name: George Kelly
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sarah Kelly
15. Birthplace: ~~Kelly~~ KENTUCKY

16 (a) Informan: Lela Kelly
(b) Address: 1310 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: C. A. Co

18 (a) Funeral director: Rayner Sanders
(b) Address: 1412 E. Preston St

19 (a) NOV 29 1948 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1948 at 1:07 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure -

Due to A. S. C. V. D.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature Emil L. Rys M.D.
Medical Examiner
Date signed 9-27-48

669005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

669005 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 W. Fayette ave & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 W. FAYETTE ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James HERMON CRAIG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Virginia R. Craig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 1867

8. AGE: Years 81 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation RETIRED
11. Industry or business Ches. & Maine R. R.

FATHER
12. Name JAMES W. CRAIG
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JULIA A. COOK
15. Birthplace MARYLAND

16 (a) Informant MRS. VIRGINIA HOOKER
(b) Address 1910 W. FAYETTE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director MM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 NOV 29 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1948, at 1345 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1948, to 11/27 1948, and that I last saw him alive on 11/27 1948.

Immediate cause of death: CARDIAC DECOMPENSATION — Duration:
Due to AURICULAR FIBRILLATION
Due to ARTERIOSCLEROTIC C. V. DISEASE
Other Conditions malignant lymphoma (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Malignant lymphoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hospital Date signed 11/27/48

VS 150

66006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 66006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3142 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARY NOWLIN DESOR

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a). Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: August William Desor, Jr.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1892

8. AGE: Years: 56 | Months: 10 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Henry Hook
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Minnie Henneger
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Charles J. Wenck
(b) Address: 3142 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 29 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 3:45a M

21. I certify that death occurred on the date above stated: that I attended deceased from 1931 to Nov. 28, 1948. And that I last saw her alive on 11-27- 1948

Immediate cause of death: Hypertensive Cardio-vascular Renal Disease — Duration: 17 years

Due to:

Due to:

Other Conditions: Diabetes Mellitus — 12 years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature A. A. Grossman M. D.
Address 1109 N. Calvert St Date signed 11-29-48

VS 150

121a

G65007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G65007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 Club Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Club Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME G. Howard Lentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada Waddington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Wholesale dealer,
11. Industry or business Cigar leaf tobacco

FATHER
12. Name George W. Lentz
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Gottert
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary Lentz Seely
(b) Address Solomon's, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 29 1948 (Registered by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to Nov. 28 1948 and that I last saw him alive on Nov 28 1948

Immediate cause of death Arteriosclerotic cardio renal disease — Duration 4 yrs.

Due to Arteriosclerosis - generalized

Due to

Other Conditions Coronary occlusion - old.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Holmes Boyd, M.D.
Address 24 E. Eager St. Date signed 11/29/48

VS 150

G65008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G65008 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mabison & Linden Ave.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Elizabeth Irwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	

6 (b) Name of husband ~~or wife~~ Marshall Irwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Feb 1872

8. AGE: Years	Months	Days	If less than one day
76	9	2	hr. min.

9. Birthplace Webster Spring W. Va. (town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Payne
13. Birthplace Webster Spring W. Va.

MOTHER
14. Maiden Name Nancy Miller
15. Birthplace Webster Spring W. Va.

16 (a) Informant Mrs. Ruth Peterman
(b) Address 5727 Newhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/1948 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Webster Spring W. Va.

18 (a) Funeral director Frank Peltz Mort
(b) Address 322 N. Howard St.

NOV 29 1948 (Date received by registrar) (Transcription from Hillsborough) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov. 1948 at 12:29 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Sept 1948 to 29 Nov 1948. and that I last saw her alive on 29 Nov 1948

Immediate cause of death Carcinomatosis (origin unknown)

Due to

Due to

Other Conditions Chr. myocarditis

(Include pregnancy within 3 months of death)

Date of operation 10/6/48; 11/15/48

Major findings of operation: Emphysema gall bladder; Ca met. in liver

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. McMorgan M. D.
Address Md. Gen. Hosp. Date signed 29 Nov 1948

VS 150

G69009 ✓ G69009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 29-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Richwood Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME GEORGE BREWER MAYO

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Minnie R. Mayo
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/12/81

8. AGE: Years	Months	Days	If less than one day
67	2	16	hr. ..... min. .....

9. Birthplace Annapolis South River, A.A. County, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Machinist

FATHER
12. Name James Mayo
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Brewer
15. Birthplace Maryland

16 (a) Informant Mr. Calvin D. Mayo
(b) Address 1520 Clarkston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director E.W. Lamourne
(b) Address 1003 W. Baltimore St.

19 (Date rec'd by registrar) NOV 29 1948 Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1948 to Nov 28, 1948 and that I last saw h, alive on Nov 28, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Chronic Glomerular Nephritis.	
Other Conditions Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy chronic glomerular nephritis arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Frank W. Bibo, Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/28/48

VS 150

66010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

66010 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 45 days

(e) Length of stay in Baltimore (yrs., mos., or days): 46 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Norway (b) County:

(c) City or town: Sandfjord (If outside city or town limits, write RURAL and give town)

(d) Street No.: Muvickon (If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country: NORWAY

3 (a) FULL NAME: LIEF NORMAN FJILSTAD

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: -- --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Fjildstad

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 5, 1893

8. AGE: Years 55 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation: Chief Engineer

11. Industry or business: Seafarer

FATHER 12. Name: Dorothea Anderson

FATHER 13. Birthplace: Norway

MOTHER 14. Maiden Name: Anton Fjildstad

MOTHER 15. Birthplace: Norway

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery or crematory: Druid Mount

Location: Baltimore Md

18 (a) Funeral director: Williams & Son

(b) Address: 129 E. Lombard St

19 (a) NOV 30 1948 (Date received by Registrar) (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Nov. 29 1948 and that I last saw h im alive on Nov. 29 1948.

Immediate cause of death: Cardiac insufficiency — Duration: unknown

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Huntington Williams, M.D.

Address: U.S. Marine Hosp Date signed: 11/29/48

VS 150

66011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 66011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3736 BROOKLYN AVE
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3736 BROOKLYN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERTHA DARLING GEORGE

3 (b) If veteran, name war —

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOSEPH GEORGE

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) JULY 28, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	29	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN ULRICK
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY BUTLER
15. Birthplace MARYLAND

16 (a) Informant MR. JOSEPH GEORGE
(b) Address 3736 BROOKLYN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1946 to Nov 26 1948 and that I last saw him alive on Nov 26 1948.

Immediate cause of death: Myocardial degeneration. — Duration

Due to

Due to

Other Conditions: Varicular Endocarditis & nephritis.
(Include pregnancy within 3 mos. of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury —

23. Signature Joseph G. Schemmel M.D.
Address 1337 S Clinton St Date signed 11/26/48

VS 130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G69012

On Hospital Disposal

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL, and give town)
(d) Street No. 2009 Clifton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Adams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-48

8. AGE: Years	Months	Days	If less than one day: hr.	min.
		8		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Disposal

18 (a) Funeral director
(b) Address

19 (a) NOV 20 1948 (Date received by registrar) (b) Tentington Williams M.D. (Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1948, at 6.45a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1948, to 11-25 1948, and that I last saw him alive on 11-25 1948.

Immediate cause of death: Pulmonary congestion. — Duration

Due to: Cardiac failure

Due to: Prematurity

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Kang M. D.
Address Johns Hopkins Hosp. Date signed 11-25-48

X

16013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 16013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: SWANNIE SNEED

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1909

8. AGE: Years	Months	Days	If less than one day
39 39	5 7	5 4	hr. min.

9. Birthplace Durham, NC. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Sneed
13. Birthplace N.C.

MOTHER
14. Maiden Name Alcie Moss
15. Birthplace N.C.

16 (a) Informant Susie Sneed
(b) Address 1212 N. Gay St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 3 48 (month) (day) (year)

(c) Cemetery or crematory Durham, N.C.
Location

18 (a) Funeral director MRS. ROBT. A. ELLIOTT & DGTR.
(b) Address 1129 N. Caroline St.

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at 10:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in factory, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner. DJM
Date signed 11-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6[illegible]014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Pennsylvania Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Lipscomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3077

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1892

8. AGE: Years 56 | Months 7 | Days 0 | If less than one day: hr. min.

9. Birthplace Jeffersville, Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Jacob Lipscomb
13. Birthplace Va.

MOTHER 14. Maiden Name
15. Birthplace Va.

16 (a) Informant Levi Lipscomb
(b) Address 2543 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles P. Law
(b) Address 802 Madison Ave Huntington Williams, Md.

19 NOV 30 1948 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to Hypertensive cardiovascular disease.

Other Conditions Acute alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in factory, or other place, or public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed November 27, 1948

X

66015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66015
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 E.Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 E.Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Fell

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia Frances Minnich
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr) Sept.10th., 1874

8. AGE: Years	Months	Days	If less than one day
74	2	8	########## hr. ########## min.

9. Birthplace Glenville, West Virginia
(Town, county, and state)
10. Usual Occupation Retired, Bookkeeper & C.P.A.
11. Industry or business

FATHER
12. Name Wesley S.Fell
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Adore McGee
15 Birthplace West Virginia

16 (a) Informant Mrs.Julia Frances Fell--- Wife
(b) Address 1909 E.Lafayette Avenue, Balto:Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.2, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Avenue, Balto:Md.

18 (a) Funeral director George J.Kuth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 30 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29th., 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1948. to Nov 30 1948.
and that I last saw him alive on Nov. 30 1948.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 week
Due to
Due to
Other Conditions Senile Psychosis — 6 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Race of Fenton M D
Address 1826 N. Mon... Date signed Dec 2

107

66016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66016
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Hammonds Ferry Rd. Lansdowne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosaria ~~D'Anna~~ LOMBARDI D'ANNA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	~~Married~~ Wid.

6 (b) Name of husband or wife late Salvatore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1875

8. AGE: Years	Months	Days	If less than one day
73	11	17	hr. min.

9. Birthplace Palermo Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Roberto Nicolicchia
13. Birthplace Italy

MOTHER
14. Maiden Name Vincenza ?
15. Birthplace Italy

16 (a) Informant Concetta Mogavero
(b) Address 2927 Hammonds Ferry Rd. Lansdowne

17 (a) Burial (b) Date thereof Nov. 30/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodbridge Memorial
Location

18 (a) Funeral director Francis Della Vecchia
(b) Address 322 S. High St.

19 (a) NOV 30 1948 (b) Harrington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 5.40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 27 1948 to Nov. 27 1948, and that I last saw him alive on Nov. 27 1948

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Hunter, M.D.
M. D.
Address Univ. Hosp.
Date signed 11 27 48

VS 53

16:0:7 BALTIMORE CITY HEALTH DEPARTMENT 16:0:7

CERTIFICATE OF DEATH

Registered No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and also name)
(d) Street No. 1613 Rickenbacker Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Schultz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	m.

6 (b) Name of husband or wife Agnes
6 (c) If wife, give age 58 years
7. Birth date of deceased (mo., day, yr.) 8-13-83

8. AGE: Years	Months	Days	If less than one day: hr	min.
65 66	3	16		

9. Birthplace New York (town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Robert Schultz
13. Birthplace Russia

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location New York City N.Y.

18 (a) Funeral director Roland E. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) Date rec'd by registrar Dec 2 1948 (b) Registrar Hunter Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948 at 8 M 20a

21. I certify that death occurred on the date above stated, that I attended deceased from 11/22 1948 to 11/29 1948 and that I last saw h[illegible] alive on 11/29 1948

Immediate cause of death Metastatic Carcinoma of tail of Pancreas — Duration

Due to

Due to

Other Conditions ASCVD • HCVD-[illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Extensive metastases to peritoneum of stomach by Carcinoma

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Jackson M.D.
Address The Johns Hopkins Hosp. Date signed 11/29/48

3018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 9th St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Brooks
3 (b) If veteran, name war V
3 (c) Social Security Account No. 212-14-5297
4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Adeline Brooks
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. June 6 1884
8. AGE: Years 64 | Months 5 | Days 23 | If less than one day hr. min
9. Birthplace Howard Co Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Edward Brooks
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden Name Catherine Howard
MOTHER 15. Birthplace Maryland
16 (a) Informant: Catherine Gibson
16 (b) Address Laurel R. F. D.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1948 (month) (day) (year)
17 (c) Cemetery or crematory Bacon Chapel
Location Anne Arundel Co Near Laurel
18 (a) Funeral director Ridgley Selby
18 (b) Address 401 Washington Laurel Md
19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1948 at 2 3/4 M
21. I certify that death occurred on the date above stated, that I attended deceased from 11-27 1948 to 12-27 1948 and that I last saw h[illegible] alive on 12-24 1948
Immediate cause of death Respiratory Paralysis — Duration
Due to Bronchopneumonia
Due to Erythema Multiforme
Other Conditions Arteriosclerotic
C-1 disease
(including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Highsaw M. D.
Address 42-29 University Pkwy 107 Date signed 12-27

VS 159

G65019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G65019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 142 W Hennetta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 W Hennetta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Pollard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/13/1890

8. AGE: Years 58 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Rhoelus Va (Town, county, and state)

10. Usual Occupation D

11. Industry or business

MOTHER | FATHER
12. Name Bebe Clark
13. Birthplace Va
14. Maiden Name unknown
15. Birthplace ?

16 (a) Informant William R Clark
(b) Address 530 Sanford Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Balto County

18 (a) Funeral director Daniel L Brown & Son
(b) Address 108 W Montgomery St

NOV 30 1948 (Date received by Registrar) (b) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/48 19 , at 3:4 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 26 19 48 to Nov 28 19 48 and that I last saw h[illegible] alive on Nov 27 19 48

Immediate cause of death Cerebral Hemorrhage — Duration 3 wks

Due to Hypertension — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Gross M. D.
Address 140 Eastern Ave Date signed Nov 29 19 48

VS 193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4301 ROLAND AVE.

(c) Hospital or institution: KIRKLEIGH VILLA

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 YEAR

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)

(d) Street No. 4301 ROLAND AVE (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME MARY THRESA BOSWELL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-1865

8. AGE: Years	Months	Days	If less than one day
83	8	21	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name FREDERICK C. BOSWELL

13. Birthplace HANOVER, GERMANY

MOTHER 14. Maiden Name ANNA M. FASNACHT

15. Birthplace MD.

16 (a) Informant HOSPT. RECORDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 2 48 (month) (day) (year)

(c) Cemetery or crematory ST. MICHAELS

Location CLEARSPRING, MD.

18 (a) Funeral director KRAISS FUNERAL HOME

(b) Address HAGERSTOWN, MD.

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 29 1948 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1948 to NOV 29 1948, and that I last saw her alive on NOV 29 1948.

Immediate cause of death	Duration
CARCINOMIA OF INTESTINES NOV	1 1948
CHRONIC MYOCARDITIS	1948.
Due to	
CHR INTERSTITIAL NEPTHRITIS	1948
Due to	
ARTERIOR SCLEROSIS	1948.

Other Conditions SENILITY

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Huntington Williams

3013 ST PAUL STREET NOVEMBER 30 1948

Address Date signed

G65021

JL- 124282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G65021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2126 Howard St. (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Virginia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 19, 1921

8. AGE: Years	Months	Days	If less than one day
27	10	9	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Foster Brooks

13. Birthplace Va.

MOTHER 14. Maiden Name Eliza Griffin

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)

(c) Cemetery or crematory MT Auburn

Location Balto City

18 (a) Funeral director Karl Jackson

(b) Address 916 Penna Ave

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948, at 11:45 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1948, to Nov. 28 1948, and that I last saw her alive on Nov. 28 1948.

Immediate cause of death Bilat bronchopneu — Duration 2 wks

Due to Resp paralysis

due to acute polyneuritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. T. Wilson

Address BCH Date signed 11-29 M. D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 D.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore – 24

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 3422 Leverton Ave

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Whichard (CATHERINE WHICHARD)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife: John L. Whichard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 21, 1903

8. AGE: Years: 44 | Months: 11 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER

12. Name: John Barton

13. Birthplace: — Maryland

MOTHER

14. Maiden Name: Katie Wachsmuth

15. Birthplace: Maryland

16 (a) Informant: Hospital Records

(b) Address: MERCY HOSPITAL, Balto., MD

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/30/48 (month) (day) (year)

(c) Cemetery or crematory: MOUNT CARMEL

Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 NOV 30 1948 (Date rec'd by registrar) Permit for Interment Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1948, to Nov. 27 1948 and that I last saw her alive on Nov. 27 1948.

	Duration
Immediate cause of death: Multiple arterial emboli	
Due to: Mitral valve thrombi	
Due to: Mitral stenosis Left ventricular hypertrophy	
Other Conditions: Arteriosclerosis Hypertension	

(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation:

Major findings of operation:

Autopsy: No above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature T. Siwinski M.D. M. D.

Address Mercy Hosp. Date signed 11/27/48

VS 150

660023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 740 N. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL MARION PEACOCK

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. (Smith)

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1870

8. AGE: Years: 78 | Months: 0 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Wholesale Seafood

FATHER
12. Name: George Peacock
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: ?
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary E. Peacock- Widow
(b) Address: 740 N. Linwood Avenue -5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH: Nov. 29 1948, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 11-29 1948 and that I last saw h/h alive on 11-28 1948.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

M. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis Vogel Jr. M. D.
Address 2611 E Hoffman St Date signed 11-29-48

VS 150

65024

AB-122212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Baylis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Vadasky

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-89-5937

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Cecelia
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) Aug. 15- 1892

8. AGE: Years	Months	Days	If less than one day
56	3	11	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Beth. Steel, Sp. Pt.

FATHER
12. Name John Vadasky (D
13. Birthplace Poland

MOTHER
14. Maiden Name Antoinette ?
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Berman Hill Road

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 NOV 30 1948 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26- 1948, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1948 to 11-26- 1948. and that I last saw h[illegible] alive on 11-26- 1948.

Immediate cause of death Fatal coma
Pulmonary Tuberculosis - miliary — Duration 7 days

Due to

Due to

Other Conditions Perianal draining sinus - 4 yrs — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Shipley M.D.
Address Balt. City Hosp. Date signed 11-27-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fulton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17 1861

8. AGE: Years	Months	Days	If less than one day
87	1	13	hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude Walter
15. Birthplace Fulton Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1948 (month) (day) (year)
(c) Cemetery or crematory Lutheran Church Cemetery
Location Fulton, Md.

18 (a) Funeral director Arthur L. Gallion
(b) Address 5-7 Washington Blvd. Funeral Home Huntington Md.

19 NOV 30 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1948, to 11/30 1948, and that I last saw h/m alive on 11/30 1948.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph L. Egonte M.D.
Address Mercy Hosp Date signed 11/30/48

VS 150

T 669026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 C

Registered No. 46:826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Dumfries Court
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Dumfries Court (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. Bozell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-4194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm. Bozell Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1899

8. AGE: Years	Months	Days	If less than one day
49	4	5	— hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Keirs Drug Store

FATHER
12. Name Charles Nalley
13. Birthplace Maryland.

MOTHER
14. Maiden Name ? Clemins.
15. Birthplace Maryland.

16 (a) Informant Mildred Riley
(b) Address 1928 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1st 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (Date received by Registrar) Nov 30 1948 Huntington Williamsport Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948, to Nov 28 1948 and that I last saw he alive on Nov. 27 1948.

Immediate cause of death	Duration
Carcinoma of Uterus	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Hall
Address 517 Scott St. Date signed 11/29/48 M. D.

VS 150

LUNGREN

G6:027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 569

G6:027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County York

(c) City or town (If outside city or town limits, write RURAL and give town) York, Jacobus

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Emma Lungren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. Lungren

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 7, 1900

If less than one day hr. min.

8. AGE: Years	Months	Days
48	6	23

9. Birthplace York, Penna. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER 12. Name	Elmer Shearer
13. Birthplace	York Co.
MOTHER 14. Maiden Name	Ellen Myers
15. Birthplace	York Co.

16 (a) Informant Kenneth E. Lungren

(b) Address 655 W. College Ave. York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 1948 (month) (day) (year)

(c) Cemetery or crematory (Jacobus) Salem

Location Jacobus, Pa.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Rd. Huntington Williams, M.D.

19 (a) NOV 30 1948 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1 1948 to Nov. 30 1948, and that I last saw h[illegible] alive on Nov. 29 1948

Immediate cause of death

Leptomeningitis } E. Coli Infection
Ependymitis }

Due to Operation wound infection

Due to

Other Conditions Posterior fossa Meningioma, Opt.

(Include pregnancy within three months of death)

Date of operation Nov. 2, 1948.

Major findings of operation: Meningioma L/F Posterior fossa.

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David Auld M.D.

Address Univ. Hosp. Date signed 11/30.

8/a

66-9028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. 66-9028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6014 York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6014 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHRYN BLANCHE COLE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Wesley Greer Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1863

8. AGE: Years 85 Months 3 Days 12 If less than one day hr. min.

9. Birthplace Claysville, Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Litle
13. Birthplace Claysville, Pa.

MOTHER
14. Maiden Name Amanda Linville
15. Birthplace Claysville, Pa.

16 (a) Informant Dr. William E. Cole
(b) Address 6014 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 3:20 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Nov 15 1948 to Nov 28 1948, and that I last saw h alive on Nov. 28 1948

Immediate cause of death: Coronary occlusion — Duration: 6 hrs

Due to: Coronary disease myocardial disease — Duration: 3

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause for which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Wilmer Stewart
Address 6 E. Read St
Date signed 11/30/48

VS 150

9029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131 B

Registered No. (16)9029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Women's Hospital
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 W. Saratoga (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Ethel Gessert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
F	W	

6 (b) Name of husband or wife Carl E. Gessert
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	17	hr. min.

9. Birthplace Chillicothe, Ohio (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Miles K. Drummond
13. Birthplace Chillicothe, Ohio

MOTHER
14. Maiden Name Effie Nichols
15. Birthplace Chillicothe, Ohio

16 (a) Informant Mr. Carl E. Gessert
(b) Address 2207 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 30 1948 (Date received by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 29 1948 and that I last saw her alive on Nov. 29 1948

Immediate cause of death: Uremia — Duration

Due to Chronic glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. C. Decker, M.D.
Address Women's Hospital Date signed 11-29-48

VS 180

66:060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

66:060 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN A. CATTERTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-0277

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie M. Catterton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	0	15	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Warehouse Foreman
11. Industry or business American Stores Co.

FATHER
12. Name: Benjamin F. Catterton
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Carrie Dalrumple
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Jean C. Wilson
(b) Address 2221 Piggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 30 1948

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:15 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/3 1945 to Nov 29 1948 and that I last saw h[illegible] alive on Nov 5 1948

Immediate cause of death: Respiratory failure — Duration: 3

Due to: Coronary occlusion

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Abrafkin M.D.
Address 601 N. Howard St. Date signed 11/29/48

66:031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 46:031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2nd Bing & Fairmount

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore 22

(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 Druid Hill Ave

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country No

3 (a) FULL NAME Mrs Nancy Kerton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 7 1877

8. AGE: Years	Months	Days	If less than one day
69	6	23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mr Jacob Myers

13. Birthplace Penna

MOTHER 14. Maiden Name Amelia Seley

15. Birthplace Penna

16 (a) Informant Hospital records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3- 48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Hill Cemetery

Location Johnston Co.

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Balt. St.

19 (a) NOV 30 1948 (b) Registered by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948 8:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/20 1948 to 11/30 1948 and that I last saw him alive on 11/30 1948. The cause of death was as follows:

Immediate cause of death Cardiac Failure Duration

Due to Diabetes Mellitus

Due to Arteriosclerosis

Due to Senile Changes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None at time

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald A. Hunt M.D.

Address Church Home & Hosp Date signed 12/3/48

VS 150

76502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 76502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Bellona + Belvedere Ave

(c) Hospital or institution: Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month

(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 12 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3333 N. Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lelia F. Frank

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife W. W. Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8th 1875

8. AGE: Years 73 | Months 1 | Days 21 | If less than one day: hr. min.

9. Birthplace Sharpsburg Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business Home

FATHER: 12. Name Nathaniel Piercy

13. Birthplace Sharpsburg Md

MOTHER: 14. Maiden Name Mary A. Spielman

15. Birthplace Williamsport Md

16 (a) Informant Mrs Mary C. Whitson

(b) Address 3333 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cem

Location Hagerstown Md.

18 (a) Funeral director John J. Cowan & Son

(b) Address 22 E-03 Washington St Hagerstown Md

19 (a) NOV 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Nov 29th 1948 at 12 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 19 1948 to Nov. 29 1948, and that I last saw h alive on Nov. 28 1948.

	Duration
Immediate cause of death Uraemia	1 wk
Due to Chronic nephritis	6 mos
Due to Chronic myocarditis	2 yrs.
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. Jnderman M. D.

Address 1136 Poplar Grove St. Date signed 11/30/48

VS 150

66:30:33

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 66:30:33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fulton F. Faulconer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mary Johnson

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1882

8. AGE: Years	Months	Days	If less than one day
66	2	22	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Faulconer
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mary Faulconer
(b) Address 428 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Mitzfeld
(b) Address 4101 Edmondson Ave

19 [illegible] 30 1948 (b) Huntington Williams M.D. Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28/48. 19 . at 6.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 47 to Nov 28 1948.
and that I last saw him alive on Nov 28 1948.

Immediate cause of death
Abdominal Metastases — Duration 1 Year

Due to Neuronoma, site unknown

Due to

Other Conditions Arteriosclerosis, generalized
(Include pregnancy within 3 months of death)

Date of operation April 1947

Major findings of operation: Extension of Neuronoma into Abdomen

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin L. Fingerhood M. D.
Address 107 St Paul St Baltimore 2 Md. Date signed 11/29/48

Medical Examiner's Case

669034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1951

Registered No. 665034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 days
(e) Length of stay in Baltimore (yrs., mos., or days): 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: DC (b) County:
(c) City or town: Washington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 711 Sixth St. (If rural give location)
(e) Citizen of foreign country? DC (Yes or No)
If yes, name country:

3 (a) FULL NAME: THOMAS JOSEPH BENJAMIN LAMPKIN

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 228-10-2341

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Bertie Lampkin
6 (c) If alive, give age: 7 years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	9	3		

9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Oiler
11. Industry or business: Seafarer

FATHER
12. Name: Tommy Lampkin
13. Birthplace: Va.

MOTHER
14. Maiden Name: Florence ?
15. Birthplace: Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 3 1948 (month) (day) (year)
(c) Cemetery or crematory: St. George
Location: St. George Md. Prince

18 (a) Funeral director: W. Lyall Gallagher Sons
(b) Address: Georgetown

19 (a) (Date received by Registrar) (b) Registrar: Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1948 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1948 to Nov. 29 1948, and that I last saw him alive on Nov. 29 1948.

Immediate cause of death	Duration
Hemorrhage from gastro-intestinal tract.	1 day
Due to: Perforation of esophagus, due to foreign body.	
Due to:	
Other Conditions:	

[illegible] M. D.
(Including pregnancy, if either a cause of death)
CORONER OR ASST. MEDICAL EXAMINER

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: November 21, 1948 M
(c) Where did injury occur? 711 Sixth St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Chicken bone perforated esophagus.

23. Signature: Jack T. James M. D.
Address: U.S. Marine Hosp. Date signed: 11-30-48

X

G69035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69035

BCH - 124313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Glen Burnie, Maryland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES FLEETWOOD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/13/75

8. AGE: Years	Months	Days	If less than one day
73	-	11	hr. min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James H. Fleetwood
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary Anna Wright
15. Birthplace Delaware

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12/1/48 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/48 19 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 to 11/29/48 19 and that I last saw him alive on 11/29/48 19

Immediate cause of death Cerebral Vascular Accident

Due to Hypertensive Heart Disease

Due to

Other Conditions Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kushen M.D.
Address Balto City Hosp Date signed 30 Nov 48

66936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66936

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. C. (b) County

(c) City or town Lincolnton (If outside city or town limits, write RURAL and give town)

(d) Street No. 303 N. Academy (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Jimmy Roland Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-15-42

8. AGE: Years	Months	Days	If less than one day
6	6	15	hr min

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Winalum Brown

13. Birthplace N. C.

MOTHER 14. Maiden Name Isabelle Wood

15. Birthplace N. C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Lincolnton

Location Lincolnton N. C.

18 (a) Funeral director Pelham Col Inc

(b) Address 1214 A Todd St

19 (a) (Date rec'd by registrar) (b) Huntington W. Va. (Burial permit)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948, to 11-30 1948, and that I last saw him alive on 11-30 1948.

Immediate cause of death: Brain abscess — Duration 3 months

Due to: Tetralogy of Fallot — life

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 30, 1948

Major findings of operation: Brain abscess Rt. frontal region

of autopsy: Tetralogy of Fallot

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert P. Green

Address Johns Hopkins Hosp. Date signed Nov 30/1948 (M D)

X

VS '50

6690.57 ✓ 6690.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5918 Glen Falls Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5918 Glen Falls Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert J. Quante

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Quante
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 12, 1888

8. AGE: Years	Months	Days	If less than one day
60	5	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Social Security Board

FATHER
12. Name William Quante
13. Birthplace Denmark

MOTHER
14. Maiden Name K. Verne Trott
15. Birthplace Alabama

16 (a) Informant Emma Quante
(b) Address 5918 Glen Falls Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul Street

19 DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1946 to 11/24 1948.
and that I last saw h alive on 11/24 1948.

Immediate cause of death — Duration

Acute Cerebral Hemorrhage

Due to Chronic Nephritis

Due to Chronic Cerebral Hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature A. H. Bornstein
Address 104 E. Biddle St. Date signed Nov. 30/48

X

VS 150

Grave #1

22621A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Found ft. of Fell St.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown (If outside city limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Male

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
? 38				

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Police Boat
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/26/48

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 26 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy (thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or most likely ☐ cause of death, fill in the following:
(a) Date of injury ? at ? M.
(b) Where did injury occur? Found ft. of Fell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public
(d) Means of injury Drowned (Found)

23. Signature George [illegible] M.D.
Medical Examiner
Date signed 9-15-4

6530.49

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 935

Registered No. 6530.49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6725 Robert Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6725 Robert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Dauts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Dauts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1878

8. AGE: Years	Months	Days	If less than one day
70	6	10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Solowska
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Frank Dauts
(b) Address 501 S. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd.

18 (a) Funeral director John C. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Interred Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 1946 to NOV 1948.
and that I last saw h[illegible] alive on NOV 29 1948.

Immediate cause of death	Duration
CORONARY THROMBOSIS	1 M
Due to HYPERTENSIVE C.V.DIS	5 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stafford C. Mackenzie M.D.
Address 6714 Holabird Ave Date signed 11/30/48

66040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52

Registered No. 66040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6 Hillside Road

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6 Hillside Road (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Grace E. Borum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Wm. D. L. Borum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1862

8. AGE: Years 86 | Months -- | Days 18 | If less than one day: hr. min. 17

9. Birthplace Harrisonburg, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Theophilus Ott

13. Birthplace Harrisonburg, Va.

MOTHER

14. Maiden Name Mary Ott

15. Birthplace Harrisonburg, Va.

16 (a) Informant Mrs. Emma D. Griffin

(b) Address 6 Hillside Road, Baltimore 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery ~~crematory~~ Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 5.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from July 4 1948 to Nov. 30th 1948, and that I last saw her alive on Nov. 30th 1948.

	Duration
Immediate cause of death [illegible]	3 months
Due to [illegible]	1 month
Due to [illegible]	Long
Other Conditions	

(Include Pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address 1300 N. Calvert St. Date signed

VS 150

66041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

66041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1727 BAKER St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1727 BAKER St (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME ROXANNA M. PRYOR (ROSA M PRYOR)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1879

8. AGE: Years 69 Months 2 Days 6 If less than one day: hr. min

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name CHARLES C PRYOR

13. Birthplace Md

MOTHER 14. Maiden Name HARRIET M SWOPE

15. Birthplace Md

16 (a) Informant K. PEARL JONES

(b) Address 1727 BAKER St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-1948 (month) (day) (year)

(c) Cemetery or crematory MT Bethel Cem

Location Frederick County Md

18 (a) Funeral director Robt Or B. M. Walters

(b) Address Brady & Strickler Sts

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Interment Withdrawn M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948 at 3 15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 30 1941 to Nov 29 1948 and that I last saw her alive on Nov 29 1948

Immediate cause of death

1) Hypertensive Cardio Vascular disease

Due to

Due to

Other Conditions Senile Cardiac Failure

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Dec

Duration
2 yrs
1 day

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Earl L Chambers M.D.

Address 4108 Liberty Hts Date signed 11/30/48

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4609 York Road
(c) Hospital or institution: Baltimore, 12 Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 9 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Rising Sun, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ollie Ruth Lindamood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Fredrick Lindamood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1873

8. AGE: Years	Months	Days	If less than one day
75	3	9	hr. min.

9. Birthplace Wytheville, Va (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Daniel Gregory Blessing
13. Birthplace Wytheville Va

MOTHER
14. Maiden Name Mary Louise Carter
15. Birthplace Wytheville, Va

16 (a) Informant Elsie Lindamood
(b) Address 4609 York Road

17 (a) Burial (b) Date thereof Dec 4 1948
(Burial, cremation, or removal) (month), (day) (year)

(c) Cemetery ~~or crematory~~ West Huntingham
Location Colgate Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948, at 10. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1948 to 11/30 1948, and that I last saw her alive on 11/30 1948

Immediate cause of death Cerebral hemorrhage. — Duration 2 hrs

Due to Hypertension

Due to Arteriosclerosis

Other Conditions CERTIFICATION APPROVED BY

(Include pregnancy within 3 months)

Major findings

Of operations CHIEF OR ASST. MEDICAL EXAMINER

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.

Address 37 W. Preston Date signed 11/30/48

66-9033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

66-9033
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1566 Richland St
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Richland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country Denmark

3 (a) FULL NAME William

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29-1938

8. AGE: Years 10 Months 9 Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Denmark
13. Birthplace Md

MOTHER
14. Maiden Name Ester Curtis
15. Birthplace Md

16 (a) Informant William Denmark
(b) Address 1566 Richland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) Date rec'd by Registrar DEC 1 1948 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948 at 2:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/29 1948 to 11/29 1948 and that I last saw him alive on 11/29 1948

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Rhetta, M.D.
Address 3rd D St Date signed 12/30 48

VS 150

30504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30504

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3056 Stafford St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3056 Stafford St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY C. MITCHELL.

3 (b) If veteran, name war: Spanish-American

3 (c) Social Security Account No. 215-01-1049.

4. Sex: Male. | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Annie M. Mitchell.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5-1872

8. AGE: Years 75 | Months 11 | Days 26 | If less than one day: 24 hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation Retired-Interior Decorator.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15 Birthplace Unknown.

16 (a) Informant James F. Mitchell.
(b) Address 3056 Stafford St.

17 (a) Burial, (b) Date thereof Dec. 2-48.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 DEC 1 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948 at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Nov. 29 1948.
and that I last saw h alive on Nov. 24 1948

Immediate cause of death

(a) Coronary Thrombosis

Due to Cardio-Vascular-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

1 hrs.

5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 40 E. 23rd St. Date signed 12-4-48

V S 150

46065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George F Fair (George W. Fair)
3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-03-8014

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rita Fair
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr) 2-22-06

8. AGE: Years	Months	Days	If less than one day
42	9	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business

FATHER
12. Name Oliver Fair
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Thompson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSP

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Baltimore

18 (a) Funeral director Phillips Herwig Sons
(b) Address 2024 Orleans St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS-50

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at 11 Le P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1948 to 11-29 1948. and that I last saw him alive on 11-29 1948.

Immediate cause of death Carcinoma of stomach & extension to liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Forgotten Ca of stomach & liver metastasis

of autopsy: Ca stomach liver metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D A Jackson

Address The Johns Hopkins Hosp Date signed 11/30/48 (M/D)

66046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. 66046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 2 days

(e) Length of stay in Baltimore (yrs., mos., or days): less than 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write U. S. Land or give town) WARWICK

(d) Street No.: 1643 [redacted] Ave. AVE (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME: STEPHEN W Richard TALLY (TALLEY) (Stephen Richard Talley)

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 212-14-8038

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 4, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	9	26		

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Mate

11. Industry or business: Seafarer

FATHER

12. Name: Stephon Tally

13. Birthplace: Md.

MOTHER

14. Maiden Name: Mary [redacted] HAUFMANN

15. Birthplace: Md.

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 3/48 (month) (day) (year)

(c) Cemetery or crematory: Mt. Carmel

Location: Balto. Md.

18 (a) Funeral director: Philip Hewig Sons

(b) Address: 2024 Orleans St.

19 (a) DEC 1948 (Date rec'd by registrar) (b) Covington Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1948, at 3:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1948 to Nov. 30 1948, and that I last saw him alive on Nov. 30 1948.

Immediate cause of death: 1-Gastroenteritis due to unknown cause

2- Syphilitic heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

Duration: 6 days Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon

Address: Clinical Director Date signed: 11/30/48

VS 180

66947 ✓ 66947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4330 Parkside Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara M. Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Rudolph Recktenwald
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Klemm
15. Birthplace Baltimore

16 (a) Informant Herman Hughes
(b) Address 4330 Parkside Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

DEC 1 1948 (a) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948, to Nov. 29 1948, and that I last saw her alive on Nov. 29 1948.

Immediate cause of death: Carcinomatosis — Duration

Due to Etiology unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H. B. Lewis, M.D.

Address 3400 Eastern Ave Date signed 11/30/48

VS 150

G6038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

G6038
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5440 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Gerland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice T. Phebus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	6	1		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Hugh Cox.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose McClend
15. Birthplace Baltimore

16 (a) Informant George T. Phebus
(b) Address 5416 Gerland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 11:47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/48 to 11/28 1948 and that I last saw her alive on 11/28 1948

Immediate cause of death	Duration
Chronic myocarditis	15 yrs
Due to Cardio-vascular renal disease	
Due to Hypertension (malignant)	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. W. Harold M.D.
4206 Harford Road
Date signed 11/29/48 (M.D.)

VS 150

66049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHRINE WINDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lr. J. K. Winder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
About 92	-	-	hr. min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benjamin F. Kershner
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Costello
15. Birthplace Maryland

16 (a) Informant Miss Margaret Heaphy
(b) Address 306 Hopkins Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. H. Ulmers and Son
(b) Address 805 N. Calvert St.

DEC 1 1948 (Date rec'd by Registrar) (b) Huntington, Indiana (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 30 Nov 1948 and that I last saw [illegible] alive on 30 Nov 1948.

Immediate cause of death: A.S.C.V.D.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Royer
Address 14 Western Pl. Date signed 12-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 66050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 N. Calhoun

(c) Hospital or institution: Franklin Sq Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt. (If outside city or town limits, write RURAL and give town)

(d) Street No. 507 Myrtle Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carrie Carroll

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	?

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 27 1914

8. AGE: Years	Months	Days	If less than one day
34	6	–	hr min.

9. Birthplace Balt Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Alexander Carroll

13. Birthplace Howard Co, Md

MOTHER 14. Maiden Name Sarah Thorton

15. Birthplace Md

16 (a) Informant Blood Blanche Mathews

(b) Address 1209 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem.

Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 (a) DEC 1 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1948, at 8:55 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1948, to Nov 27 1948, and that I last saw h er alive on Nov 27 1948

Immediate cause of death: cardiac decompensation — Duration

Due to: Rheumatic heart disease — 10 yr

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq Hosp Date signed 11-27-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

68051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 68001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, as given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1047 Brantly Ave

(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.,

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town) 1047 Brantly Ave

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Eugene Calhoun

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-5950A

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 10 1875

8. AGE: Years 73 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mesmenger

11. Industry or business

FATHER 12. Name John Calhoun

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Isabella Johnson

15. Birthplace Baltimore Md

16 (a) Informant Fsnnie Smith C.

(b) Address 1047 Brantly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Arburn Cem.

Location Baltimore Md

18 (a) Funeral director Elroy C Wilson

(b) Address 1000 Brantly Ave.

19 (a) (Delivered by registrar) (b) Huntington Williams, M.D. Registrar

11-30-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30- 1948 at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1948 to 11/30 1948. and that I last saw him alive on 11-30-1948

Immediate cause of death

(a) Cardio-Vascular Renal Disease

Due to

(b) Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration 1 year

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. H. Jackson M.D.

Address 1000 Arlington Ave Date signed 12/7/48

VS 150

66502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. 66502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution: Bar-Wil-Ba Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Leadenhall (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Watts.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-12-1870

8. AGE: Years	Months	Days	If less than one day
78	-	18	hr. min.

9. Birthplace Calvert Co. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Joseph A. Jurey
(b) Address 640 W. Barre St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30th 1948, at 2 A; M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28-1948 to 11-30-1948, and that I last saw her alive on November 29 1948

Immediate cause of death: Cancreme both Legs. Arterio sclerotic. — Duration: 1 year

Due to: Cardio-Renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 900 N. Arlington Ave Date signed 11-30-48

VS 150

46:0:53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10½c

46:0:53

Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Every item of information must be given. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 253 N. Bruce St.

(c) Hospital or institution: Univ. Hosp. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 253 N Bruce Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Preston Baynor

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 29 1948 Nov. 29 1948 and that I last saw h[illegible] alive on Nov 29 1948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1945

8. AGE: Years	Months	Days	If less than one day
3	8	6	hr. min

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James G. Baynor

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Mary Holley

15. Birthplace Baltimore Maryland

16 (a) Informant James G. Baynor

(b) Address 253 N Bruce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore Md

18 (a) Funeral director Joseph A. Lively

(b) Address 66 West Base Street

19 DEC 1 1948 (Registrar) (b) [illegible] Washington Boulevard

Immediate cause of death: Respiratory failure

Due to Laryngotracheobronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. C. Hunter, M.D.

Address Univ. Hosp. Date signed 11 29 48

VS 153

16-50-A 292317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 45F

Registered No. 66-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk - (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 269 A. Route 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Collingsworth
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-91

8. AGE: Years 57 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Hostler
11. Industry or business Bethlehem Steel

FATHER
12. Name George Collingsworth
13. Birthplace Ky.

MOTHER
14. Maiden Name Louisa McDaniel
15. Birthplace Ky.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rogers Ave. Ellicott City, Md

18 (a) Funeral director Easton & Sons
(b) Address Ellicott City, Md.

19 (a) DEC 1 1948 (b) Huntington, Indiana, Mch
Registrar

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Nov. 25, 1948 1 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 8 1948 to Nov. 25 1948 and that I last saw h alive on Nov. 25 1948

Immediate cause of death	Duration
Pneumonia	
Due to Infiltration by carcinoma	
1) naso pharynx into Brain	
Due to Metastasis	
Other Conditions Intestinal obst.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Hospital Date signed 12-2-48 M D

-2

6690:5

Exhibit # 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 6690:5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U N (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) X N
(d) Street No. (If rural give location) N
(e) Citizen of foreign country? (Yes or No) U N W N
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: 55 | Months | Days | If less than one day: hr min

9. Birthplace U N (Town, county, and state)

10. Usual Occupation U

11. Industry or business W N

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden Name N
15. Birthplace U

16 (a) Informant W N
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/26/47 (mo., day, yr.)
(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 26 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 7.40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage (subdural)

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 7 at ? M.
(b) Where did injury occur? Found 701 Fleet St.
(c) Did injury occur at home, on farm, industrial place, or public place? Public (Specify)
(d) Means of injury? Unknown

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 8/25/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. (illegible)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 East Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1901

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	4	8		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Benjamin Franklin Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary MacNerny
15. Birthplace Washington D.C.

16 (a) Informant Stella Berger
(b) Address 809 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Geo McGinnis Son
(b) Address 811 N Wolfe St

19 DEC 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1948, at 11.10 P.M.

21. I certify that I took charge of the remains described above, held an Inquir & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-29-48 at approx. 11.00 A.M.
(b) Where did injury occur? Baltimore City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? hospital While at work? NO
(d) Means of injury Jump from high place

23. Signature Emil L Ryan M.D.
Medical Examiner, Md.
Date signed November 30, 1948

VS 12

66905 7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

66407
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 260 N. Bruce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 260 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Williams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	5	20		

9. Birthplace Howard County, Md.. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alexander Williams
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Rosella Henson.
15. Birthplace Howard Co. Md..

16 (a) Informant Genevieve Jones.
(b) Address 260 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 1948 Dec 1 Huntington Williams, M.D.
(Date received by registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1948 to 11/29 1948. and that I last saw her alive on 11/23 1948

Immediate cause of death Myocardial Failure

Due to Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 60 W. Conway St. Date signed 12/2/48

G69058

JL - 124776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 8

46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town altimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 N. Vincent St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Matthew Crowner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1881

8. AGE: Years	Months	Days	If less than one day hr	min
67 yrs.	4.	14		

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jim Crowner (D

13. Birthplace ?

MOTHER

14. Maiden Name Sarah Cooper (D

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Star.

Location Catonsville Md.

18 (a) Funeral director Mrs Katee R. Williams

(b) Address 322 N. Schroeder St

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 2.45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 22 1948 to Nov. 27 1948. and that I last saw him alive on Nov. 27 1948

	Duration
Immediate cause of death Bronchopneumonia	2 days
~~Due to~~ Carcinoma of the Stomach	6 mo.
Due to	
Other Conditions Dongrene of right foot	2-3 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature L. S Stutzman M. D.

Address Balto. City Hosp. Date signed 11-28-48

VS 150

6690:9 ✓ 6690:9

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. .....

CERTIFICATE OF DEATH 12/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 670 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Butler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Alexander Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 1894

8. AGE: Years 57 | Months - | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md.

16 (a) Informant Alexander Butler
(b) Address 670 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by Registrar) (b) Washington Williams (Signature of Registrar)

DEC

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 . at 11:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-7-48 19 to 11-26-48 19 and that I last saw h[illegible] alive on 11-23-48 19

Immediate cause of death Uremia Nephritis

Due to Nephritis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
[illegible]
[illegible]
[illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex L. Edmondson M.D.
Address 10 S. Edmondson Ave Date signed 11-30-48

PLEASE WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK. Every item on this certificate should be answered; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66960 BALTIMORE CITY HEALTH DEPARTMENT 66960
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 W. Franklin St.
(c) Hospital or institution:
University Hoapital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 W. Franklin St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry ~~Harry~~ McCobbin McCobbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

20. DATE OF DEATH November 27, 1948 at 11:15 P.M.

6 (b) Name of husband or wife Theresa McCobbin

6 (c) If alive, give age years

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE: Years	Months	Days	If less than one day
64 yrs.	4	23	hr. min

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

9. Birthplace Harpers Ferry, West Virginia
(Town, county, and state)

10. Usual Occupation Baggage man

11. Industry or business B & O, Camden Station

FATHER
12. Name Benton McCobbin
13. Birthplace Harpers Ferry, West Virginia

MOTHER
14. Maiden Name Bettie ?
15. Birthplace Harpers Ferry, West Virginia

16 (a) Informant Theresa McCobbin
(b) Address 658 W. Franklin St.

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

17 (a) Burial (b) Date thereof December 1, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount ~~Albion~~ Auburn
Location

18 (a) Funeral director Katie Williams
(b) Address 322 N. Schroeder St.

23. Signature Earl L. Royston M.D.
Medical Examiner
Date signed 12-2-48

19 (a) (b)
(Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15!

G69061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G69061

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3609 Menlo Drive.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Yrs. 20

(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3609 Menlo Drive. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME AARON ROTHSCHILD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Addye B. Rothschild.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1859.

8. AGE: Years	Months	Days	If less than one day
89	9	28	hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Retired Bookkeeper.

11. Industry or business

FATHER

12. Name Zadok Rothschild,

13. Birthplace Germany.

MOTHER

14. Maiden Name Violet Nusbaum,

15. Birthplace Germany.

16 (a) Informant Mrs. Addye B. Rothschild,

(b) Address 3609 Menlo Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48. (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Harris Sonnenschein & Son

(b) Address 1902 Eutaw Place.

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th. 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to November 1948. and that I last saw h l M alive on 29 Nov. 1948

Immediate cause of death Bronchopneumonia

Due to Arteriosclerosis, generalized

Duration Weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. C. Isenberger Jr. M. D.

Address 1207 Eutaw Place Date signed

VS 150

G69062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G69062

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3618 Glen Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3618 Glen Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Clarence Kell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	W.

6 (b) Name of husband or wife Helen Agnes (Nellie)

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min
73	2	19		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Broker.

11. Industry or business

FATHER

12. Name Peter Kell

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Honorah Sullivan

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Alice Fairbank

(b) Address 3618 Glen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director Lazaro Bueno

(b) Address 5005 Park Heights Ave

19 (a) ..... (b) ..... (Date received) (Registrar) Registrar

DEC 1 1948 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948, at 2:18 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948, to Nov. 1948, and that I last saw him alive on Nov 29 1948.

Immediate cause of death	Duration
Carcinoma of sigmoid colon	4-5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 1947

Major findings of operation: Inoperable carcinoma of sigmoid colon

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)

(e) Means of injury

23. Signature Herbert H. Gundersheimer, Jr. M.D.

Address Riviera Apts. Lake Dr. Date signed Nov. 29, 1948

Please write plainly, with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

G6:90:63

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G6:90:63
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2939 Presbury St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2939 Presbury St (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME Gladys Carroll Keeney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Arthur D. Keeney 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 24, 1907

8. AGE: Years	Months	Days	If less than one day
41	-	5	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Carroll Brown
13. Birthplace Chestertown, Maryland

MOTHER
14. Maiden Name Marion Hurlstine
15. Birthplace Maryland.

16 (a) Informant Mrs Arthur D Keeney
(b) Address 2939 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-48 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Forest Hills Md.

18 (a) Funeral director Edmund Boyce
(b) Address 5225 Liberty Heights Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

Huntington for Williams & Co

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 19 at 8 03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to 12/1/48 19
and that I last saw h alive on 12/1/48 19

Immediate cause of death Pneumonia
From Concurrence
of Cold

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: Cold
for Pneumonia
of autopsy: Cold

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature [illegible]
Address 3033 W North Ave Date signed 12/1/48 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to give correct age in years. If less than one year, give age in months, days, hours or minutes. Name of deceased should be given in full. Occupation should indicate the trade, profession or particular kind of work done during most of working life, even though deceased was retired at time of death. Industry or business should indicate the name of the establishment in which deceased was employed. Physicians: please write the causes of death clearly and legibly.

Herbert P. Case 66-19854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 66504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, and the information should be carefully applied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Gwynn + Fairmount

(c) Hospital or institution: South Mo + Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 426 Murdock Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Angelina T. McClintock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Frederick T. McClintock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 27 1881

8. AGE: Years	Months	Days	If less than one day
67	9	2	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr. Paul R. Younts

(b) Address 426 Murdock Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Ebenezer Cem.

Location Charlotte, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/48 19 at 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/18/48 to 11/29/48 19 48 and that I last saw h alive on 11/29/48.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to Probable CVA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None at time

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald W. Mintz M.D.

Address Charlotte N.C. Date signed 12/3/48

VS 157

66805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 66805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3302 Powhatan Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3302 Powhatan Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH E. LEWIS

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertha C. Lewis

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1875

8. AGE: Years: 73 | Months: 9 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Centerville, Mass. (Town, county, and state)

10. Usual Occupation: Pres.

11. Industry or business: Jos. E. Lewis & Co., Inc.

FATHER

12. Name: Joseph Freeman Lewis

13. Birthplace: Mass.

MOTHER

14. Maiden Name: Emma Hinckley

15. Birthplace: Mass.

16 (a) Informant: Mr. William W. Saunders

(b) Address: 203 Goodale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) Date rec'd by Registrar (b) Registrar

DEC 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-1-1940 to 11-30-1948 and that I last saw alive on 11-30-1948

Immediate cause of death

Due to Myelogenous Leukemia — Duration 2 yr.

Due to Acute Sclerotic Cardiac disease — Duration 5 —

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard Fisher Lyon M.D.

Address 2604 Garrison Blvd Date signed 12-1-48

66801-6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

66801-6 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be currently supplied. Its correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution: Home for Aged of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE M. FULLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William F. Fuller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1863

8. AGE: Years 85 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER 12. Name James E. Johnson
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary E. Wherrett
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Miriam C. Coates, Supt.
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director W.M. J. TICKNER & SONS
(b). Address Balto., Md.

19 (a) [illegible] (b) Geo. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, [illegible] at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Nov 29 1948 and that I last saw her alive on Nov 29 1948.

	Duration
Immediate cause of death: Myocardial insufficiency	1 wk
Due to: Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause (A, B, C or D) which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

25. Signature Arthur J. Dimes M.D.
Address 800 N. 33rd St Date signed 11-30-48

66807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66807

42a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2025 Ellsworth St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John W. Woodruch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1893

8. AGE: Years	Months	Days	If less than one day
55	3	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Sadie Slacum
(b) Address 3215 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Ex. Balto. Md.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. Md.

19 (a) 1 1948 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov. 1948 at 9.50P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Vascular Accident

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner
Date signed 30 Nov. 48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66,0,8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66,0,8

Registered No. 159

Hospital Disposal

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Essex –
(If outside city or town limits, write RURAL and give town)

(d) Street No. 13 Marus Ave –
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Short Twin A

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/48

8. AGE: Years | Months | Days | If less than one day: hr. min

Years	Months	Days	If less than one day
		1	hr. min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Short
13. Birthplace Md

MOTHER
14. Maiden Name Doreen Buckley
15. Birthplace England

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/5/48 to 11/6/48, and that I last saw he alive on 11/6/48.

Immediate cause of death — Asphyxia neonatorum — Duration

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. C. Hamp M. D.

Address Johns Hopkins Hosp Date signed 11-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V2 150

over

D-94-A

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

66506-9

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore Co

(c) City or town Essex (If outside city or town limits, write RURAL, and give town)

(d) Street No. 13 Marie Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby "Boy B" Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 11-6-48

8. AGE: Years | Months | Days | 12. If less than one day: hr. min

Years	Months	Days	hr.	min.
		1	36	

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Joseph Short

13. Birthplace Md

MOTHER — 14. Maiden Name Doree V. Buckley

15. Birthplace England

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1948 at 10:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-6 1948 to 11-7 1948, and that I last saw him alive on 11-7 1948

Immediate cause of death: atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature a. c. hamy M. D.

Address Johns Hopkins Hosp Date signed 11-5-48

VS 150

G540.0 — Square #3 — G6?0.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, as the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
55				

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/30/48

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 30 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, fold that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration
Fatty degeneration of liver, Chronic alcoholism.
Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Emil L. Rogen M.D.
Medical Examiner
Date signed 8-31-48

VS 151

G6:071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G6:071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3047 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3047 Abell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNA ADELE FRIEDEL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: --
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 9, 1900
8. AGE: Years: 48 Months: 6 Days: 20 If less than one day: hr. min
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Bookkeeper
11. Industry or business:
FATHER 12. Name: John C. Friedel
13. Birthplace: Baltimore
MOTHER 14. Maiden Name: Katharine Schisler
15. Birthplace: Sweet Aire, Balto. Co., Md.
16 (a) Informant: Mrs. Clara F. Brown
(b) Address: 2703 N. Calvert St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.
18 (a) Funeral director: WM. J. TICKLER & SONS
(b) Address: Baltimore, Md.
19 (a) DEC 1 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Nov. 29 1948 and that I last saw her alive on Nov. 29 1948.

	Duration
Immediate cause of death: Coronary thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [signature]
Address 2400 Eastern Ave. Date signed 11/30/48

G6:072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G6:072
Registered No. 928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4806 Laurel Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4806 Laurel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCES LEE HEARN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Wm. J. Hearn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	0	13	hr. min.

9. Birthplace Del. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Hudson
13. Birthplace Del.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Ola H. Gaither
(b) Address 4806 Laurel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 1 1948 (b) Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:00a. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 27 1947 to Nov 29 1948 and that I last saw h alive on Nov 29 1948.

Immediate cause of death
Mitral Insufficiency
Due to Cardiac Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1/27/47

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mrs. O. H. Gaither
Address 1803 Park Heights Ave. Date signed 11/30/48 M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information, should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 6[illegible]0.73

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Chestnut Hill Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL MORAN - also known as MICHAEL GATTO

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 214-01-1185

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Miles Moran
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) June 22, 1901

8. AGE: Years 47 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Hairdresser
11. Industry or business Hutzler Bros.

FATHER
12. Name Giuseppe Gatto
13. Birthplace Italy Pa.

MOTHER
14. Maiden Name Rosalie Sanskey
15. Birthplace Italy

16 (a) Informant Mrs. Helen I. Moran - wife
(b) Address 521 Chestnut Hill Ave. -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2. 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md.

18 (a) Funeral director MEARBY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) [illegible] (Date rec'd by Registrar) Huntington Williamsport

DEC - 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 19 48 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 19 48 to Nov. 29 19 48, and that I last saw him alive on Nov. 29 19 48.

Immediate cause of death: Coronary insufficiency — Duration: unk

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray Howard, M.D.
Address U.S. Marine Hosp Date signed 11/29/48

VS 150

66907 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 66074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or Institution: St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1739 Cliftview Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Lee Bogy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Charles F.

6 (c) If alive, give age years

7. Birth date or deceased (mo., day, yr) January 1[illegible] 1864

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	10	10		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER	12. Name	Not Known
	13. Birthplace	" "
MOTHER	14. Maiden Name	" "
	15. Birthplace	" "

16 (a) Informant Mrs. Lottie Sturgeon

(b) Address 1739 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Harford Rd.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway.

DEC 1 1948 (Date rec'd by registrar) Wilmington for Williams, M.E.

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH November 28, 1948 at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1948 to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

	Duration
Immediate cause of death - Cardio-respiratory failure	
Due to Hypostatic Pneumonia	
Due to Fractured femur - Left.	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED

Major findings of operation: Thomas J. Mullis, M.D.

for: Wm. G. Helfrich

of autopsy: Chief Deputy Asst. Medical Examiner

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/C

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Nov. 6, 1948 at ? M

(c) Where did injury occur? 1739 Cliftview Ave. Balto. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (While at work) no

(e) Means of injury slipped and fell to floor

23. Signature [illegible] St. Joseph Hospital signed 11/30/48

Address

For Coroner Byrnes

66075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Baltimore Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Belair (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy N. Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of husband or wife Caroline V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3rd 1864

8. AGE: Years	Months	Days	If less than one day
84	9	27	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Self

FATHER 12. Name Wm Blackwell

13. Birthplace Va.

MOTHER 14. Maiden Name Julia Nutt

15. Birthplace Va.

16 (a) Informant Leroy N. Blackwell Jr

(b) Address 1530 Bolton St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-2-48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Georgetown

Location Va.

18 (a) Funeral director William Cook Inc.

(b) Address 1247 St. Paul St

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1948, at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 12/1 1948, and that I last saw him alive on 11/30 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J Blazek M. D.

Address Date signed 12/1/48

VS 150

669076 Neale

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

669076 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Bon Secours 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)

(d) Street No. 312 Paddington Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Harriet E. Neale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Leonard E. Neale Jr.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Jan 28 1898

8. AGE: Years 50 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Howard L Smith

13. Birthplace Frederick Co Md

MOTHER 14. Maiden Name Leona Thomas

15. Birthplace Frederick Co Md

16 (a) Informant Mrs. J Duncan Watson

(b) Address 224 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto, Md

18 (a) Funeral director Henry W Kenyon & Sons Co

(b) Address 492 York Rd.

19 (a) (Date received by Registrar) DEC 2 1948 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 · 1 · 1948, at 2 45p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 · 9 1948, to 12 · 1 1948, and that I last saw her alive on 12 · 1 1948.

Immediate cause of death: Respiratory failure — Duration: 6 months

Due to Left sided Brain tumor

Due to

Other Conditions Rt sided Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature McCallagher M. D.

Address Bon Secours Hospital Date signed 12-2-48

66:0.47

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 66:0.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Lesterstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Lesterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Michael Wolfe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 1868

8. AGE: Years 80 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Dr. Samuel B Wolfe
(b) Address 2714 Lesterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery or crematory Beth Isaac
Location No Point Germania Hill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1948 at 7 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 12-1- 1948.
and that I last saw him alive on 11-30- 1948

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: several years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. A. Sussman M. D.
Address 1107 N. Calvert St Date signed 12-2-48

VS 50

669078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

669078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2483 Sherley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2483 Sherley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Kupides

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kolman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Raymond Kupides

(b) Address 2483 Sherley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)

(c) Cemetery or crematory Sherrie Rosh

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (Date received by registrar) DEC 2 - 1948 Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 at 1:52 P M

21. I certify that death occurred on the date above stated, that I attended deceased from: (a) 1941 to (b) 12/1/48 and that I last saw h alive on 12/1/48

Immediate cause of death: Coronary astriosclerosis — Duration: 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raymond Kupides

Address 2320 Eutaw Pl Date signed 12/1/48 M

VS 150

66907 | BALTIMORE CITY HEALTH DEPARTMENT | 66907

CERTIFICATE OF DEATH

94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Stonewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Stonewood Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Charles J. Gordon

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-09-4527

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine J. Donnelly
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr) March 4, 1899

8. AGE: Years	Months	Days	If less than one day
49	8	26	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Employ

FATHER
12. Name John L. Gordon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Theresa Milski
15. Birthplace Baltimore

16 (a) Informant Mrs. Katherine Gordon
(b) Address 1307 Stonewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore

18 (a) Funeral director Rita Wendfeld
(b) Address 900 East Biddle St.

19 (a) DEC 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1948 at 8:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Nov. 30 1948 and that I last saw h[illegible] alive on Nov. 29 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 hrs
Due to Angina Pectoris — Duration 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. J. Granger M.D.
Address 402 E. Lanvale Date signed 12/1/48

VS 155

66:060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

66:456

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden Ave.

(c) Hospital or institution: Maryland General Hosp. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1118 Division St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Ware

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Cd	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-1900

8. AGE: Years 48 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Ware Sr

13. Birthplace

MOTHER 14. Maiden Name Ella Scott

15. Birthplace

16 (a) Informant Mrs Ella Ware

(b) Address 1118 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs Francis A. Humphrey

(b) Address 518 W. Biddle St.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948, at 8:27 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Nov. 1948, to 30 Nov 1948, and that I last saw him alive on 30 Nov 1948.

Immediate cause of death	Duration
Mediastinitis	
Due to Perforation of esophagus	
Due to Gastric chr. ulcer w esophagus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 29 Nov. 48

Major findings of operation: No obl. pathology

of autopsy: Rupture of esophagus

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M.T. McGoogan M.D.

Address Md. Gen. Hospital Date signed 1 Dec 1948

VS 150

60903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 60903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 647 W. Mulberry St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-12

8. AGE: Years 36 Months 8 Days 18 If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Arthur Briggs

13. Birthplace Va.

MOTHER 14. Maiden Name Annie Gray

15. Birthplace Va

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month, day, year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mr. Francis A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) [illegible] (Signature of registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 48 at 7 3/4 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-26 48 to 11-30 48. and that I last saw her alive on 11-30 48

	Duration
Immediate cause of death Uremia	
Congestive Failure	2 mo.
Due to Hypertensive Cardio Vascular disease	5 yrs
Due to	
Other Conditions Nephro Sclerosis	

(Include conditions contributing to the death but not related to the disease causing death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the cause for which death should be charged, statistically.

of autopsy: Hypertensive Cardio Renal Disease

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City, town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard S Ross

Address The Johns Hopkins Hosp. Balto 5 Date signed 12/1/48

VS 150

COURISEY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 66302 ✓ 66302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as required by law. Much of information should be obtained from informants, but the cause of death must be certified by physician. Physicians: please write the causes of death clearly and legibly. Answer all questions, and make entries in every item for which you have the information. If any item is unknown, state the fact. Do not use ditto marks. Be sure that the personal particulars are entered correctly and that the statement of cause of death is complete, as the certificate cannot be changed after it has been filed. Underlining is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N. Carey St.

(c) Hospital or institution: Bon Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Davis (If outside city or town limits, write RURAL and give town)

(d) Street No. 207 Fulton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jas P. Courisey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	Widower

6 (b) Name of husband or wife Edwin Deander

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 2, 1893.

8. ACE: Years	Months	Days	If less than one day
55	4	29	hr. min.

9. Birthplace Cambridge, Md (Town, county, and state)

10. Usual Occupation Steredor

11. Industry or business

FATHER

12. Name Louis Courisey

13. Birthplace Cambridge, Md

MOTHER

14. Maiden Name Emma Graham

15. Birthplace Md

16 (a) Informant Claudia M. Simpson

(b) Address 713 Dorsey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Joseph L. Wilkes

(b) Address 1207 N. Central Ave

19 (a) DEC 2 - 1948 (Received by registrar) (b) Municipal Building (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 (Month) (Day) (Year) 10 AM PM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/30/48 to 12/1/48 and that I last saw h[illegible] alive on 11/30/48

Immediate cause of death: Carcinoma

Duration: 2 mos.

Due to Uremia

Due to Hypertension

Other Conditions

(Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

I attended the deceased from 11/30/48 to 12/1/48 I last saw the deceased alive on 11/30/48 Cause of death as stated above is true to the best of my knowledge and belief. Underlying cause to which death should be charged, if any, is entered immediately above.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos. A. Hooper M.D.

Address 10 S. Division St. Date signed 12-2-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. (illegible)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 N. Wolfe Street
(c) Hospital or institution:

6-44

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside the town limits, write RURAL and give town)
(d) Street No. 413 N. Wolfe Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-9-1880

8. AGE: Years: 68 | Months: 2 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Euey Gross
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Priscilla ?
15. Birthplace: Maryland

16 (a) Informant: Louis Brooks
(b) Address: 413 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-4-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A. A. County, Md.

18 (a) Funeral director: Joseph L. Locke, Jr.
(b) Address: 2044 N. Central Ave

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) (illegible)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 10:10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry had that said deceased came to her death on the day stated above, and death, in my opinion resulted from natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Hypertensive Cardiovascular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature (illegible) M.D.
Medical Examiner
Date signed 11/30/48

VS 151

Please write plainly, with pen and ink. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63084 Dec 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

Registered No. 63084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 692 Washington Blvd (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME Peter Plane
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-79

8. AGE: Years 69 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Billy Plane
13. Birthplace Greece

MOTHER 14. Maiden Name Georgia ?
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lamond Inc.
(b) Address 438-40 E. North ave

19 DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1948 at 6 12 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-1 1948 to 11-30 1948, and that I last saw h[illegible] alive on 11-30 1948

Immediate cause of death Renal Insufficiency — Duration
Due to Bilateral nephrolithiasis
Due to
Other Conditions
(Include pregnancy within 3 mos. of death)

Date of operation 11-22-48
Major findings of operation: nephrolithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Kelly M.D.
Address Johns Hopkins Hosp Date signed 11-30-48 M.D.

VS 150

G680685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G680685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARSHAL L. NORRIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-5543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Divorced

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1899

8. AGE: Years	Months	Days	If less than one day
49	4	17	hr. min.

9. Birthplace Rosyln, Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Coal Truck

FATHER
12. Name Lloyd Norris
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria ?
15. Birthplace Maryland

16 (a) Informant Ida Derricks, sister
(b) Address 1034 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-48 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Randallstown, Md.

18 (a) Funeral director Samuel W. Sullivan, Jr.
(b) Address 1011 N. Arlington Ave.

DEC 2 - 1948 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1948, at 1.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rey M.D.
Medical Examiner
Date signed December 2, 1948

G690686 ✓ G690686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1726 N.Wolfe Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) 52 ##Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1726 N.Wolfe Street (If rural give location)

(e) Citizen of foreign country? No Yes or No

If yes, name country

3 (a) FULL NAME Minnie I. Atzrodt (Minnie Berry Atzrodt)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Claude Atzrodt

6 (c) If alive, give age D years

7. Birth date of deceased mo., day, yr Jan.12,1880

8. AGE: Years	Months	Days	If less than one day
68	10	20	########## min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Martin L.Widerman

13 Birthplace Baltimore, County

MOTHER

14. Maiden Name Susan Mullinaux

15 Birthplace Baltimore, County

16 (a) Informant Mrs.Lydia W.Sheffer (Sister)

(b) Address 3134 Woodhome Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.4,1948 (month) (day) (year)

(c) Cemetery or crematory Mt.Olive Cemetery

Location Randallstown, Balto:Co.Md.

18 (a) Funeral director George J.Ruth, Inc.

(b) Address 1735 Harford Avenue

DEC 2 - 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec 1948, at 8 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1948 to Dec 1 1948, and that I last saw h alive on 29 Nov 1948.

Immediate cause of death	Duration
(a) Coronary occlusion	
Due to (b) Coronary arteriosclerosis	5 yrs.
Due to (c) Generalized arteriosclerosis	
Other Conditions Diabetes with amputation both legs (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Henry J. Conolly

Address 13 E. Eager St. Date signed Dec 1 1948

94a

VS 150

66:087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 66:087

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1306 E. Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

Street No. 1306 E. Pratt St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME GEORGE W. HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-5720

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Martha Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1885

8. AGE: Years	Months	Days	If less than one day
63 43	11. 10	25 5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Insurance + Trust Co

11. Industry or business

FATHER 12. Name John. Howard

13 Birthplace Baltimore

MOTHER 14. Maiden Name Margaretta Ward

15 Birthplace Baltimore Md

16 (a) Informant Martha Howard

(b) Address 1306 E. Pratt st

17 (a) [illegible] Burial (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day)

(c) Cemetery or crematory Baltimore Cem

Location North ave + Rose st

18 (a) Funeral director Kendall Roper

(b) Address 312 S. Highland ave

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov 30 1948.

and that I last saw alive on Nov 29 1948.

Immediate cause of death Bronchogenic Carcinoma — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature Nelson L. Sisson

Address 129 S. Broadway Date signed 12/1/48

VS 15?

66:088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 66:088

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or ~~Institution~~ St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 423 N. Bond (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a). FULL NAME Mattie Lee Cabell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	

6 (b) Name of husband or wife George Cabell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	5 6	28		

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Henry Hope

13. Birthplace Georgia

MOTHER

14. Maiden Name Mattie White

15. Birthplace Georgia

16 (a) Informant Rev. Hay Tunsell

(b) Address 423 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery Cem.

Location Brooklyn Md.

18 (a) Funeral director Elroy C. Wilson

(b) Address 1000 Brantly Ave

DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams Mar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 1948 to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to - Hypostatic pneumonia	
Due to Uremia	
Other Conditions Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: - Cholecystitis - Tuberculosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Eugene J. Cibley

Address 2 Longwood Apts Date signed 11/29/48

X.

VS 150

Please print plainly, with pen. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

669089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

669089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 09 Murdock Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. John Joseph Volz (Augusta) AUGUSTA ELIZABETH VOLZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife John Volz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	8	8		

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr. George Buck
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amelia Bowers
15. Birthplace Pennsylvania

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St., Huntington Williams, Mgr.

19 DEC 2 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1948 to Nov 30 1948 and that I last saw her alive on Nov. 30 1948

Immediate cause of death: Chronic congestive heart failure — Duration: 3 weeks

Due to: Arterio sclerotic heart disease — years

Due to:

Other Conditions: diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature Francis A Walt, M.D.
Address Union Memorial Hosp Date signed 11-30-48

93 D

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure and answer correctly every question where an answer is required. Do not report "Old Age" as the cause of death, but the disease or condition directly causing death. Operations should be reported only when performed for some other cause than that given as the cause of death. Any statement of duration of disease, or of age of deceased, should be as exact as possible. Omissions, alterations or illegible entries cause unnecessary delay and may require return of certificate. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly

66050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 66050

66050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Gough Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Gough Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kavanaugh

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/ 1877

8. AGE: Years	Months	Days	If less than one day
71		5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Garrett Kavanaugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Nevin
15. Birthplace Ireland

16 (a) Informant Mrs. Bridget Mary Lewis
(b) Address 2117 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/ 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Ave. Balto. Md.

18 (a) Funeral director Lilly & Zeiler, Inc
(b) Address 403 S. Wolfe St.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 19 48, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 19 48, to Nov. 30 19 48, and that I last saw her alive on Nov. 29 19 48.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm D Ickard M. D.
Address 701 N. Kenwood Ave. Date signed 12/1/48

669091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13R

669091 Registered No.

LCH-124605

Physicians: please write the causes of death clearly and legibly. Information required is especially important. Be sure that all items are correctly answered.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joe P. Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/17/1898

8. AGE: Years	Months	Days	If less than one day
50	5	6	hr. min.

9. Birthplace Fla. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joe Kelly (d)
13. Birthplace ?

MOTHER
14. Maiden Name Mary Lason (d)
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Funeral Director Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/48 19 to 11/23/48 19 and that I last saw him alive on 11/23/48 19

Immediate cause of death San Advanced Pulmonary Tuberculosis — Duration 1 yr.
Due to
Due to
Other Conditions Portal cirrhosis ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Slaughter M.D.
Address Balto - City Hosp. Date signed 11-30-48

VS 150

(63092 ES-124748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. 63092

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 831 S. Linwood Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Seyfferth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	17	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Continental Can Co.

FATHER 12. Name Frank Seyfferth

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace Germany

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda

(b) Address 2229 Haldeion St.

19 DEC 2 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1948, at 4:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-21 1948 to 11-30 1948 and that I last saw h in alive on 11-30 1948.

Immediate cause of death Bronchopneumonia Duration 3 days

Pulmonary Edema

Due to Hypertensive Cardio-vascular disease with failure

Due to

Other Conditions Peptic ulcer Esophageal Varices; Anemia (Include pregnancy within 3 months of death)

Dat of operation 11/26/48

Major findings of operation: Peptic Ulcer (Gastric)

of autopsy: same as above

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank S. Kandt M.D.

Address Balt. City Hosp Date signed Dec 1, 194

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156a

Registered No. 66803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Carey Streets
(c) Hospital or institution:
Good Samaritan Nursing Home 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Payson Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ACIE CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Rita Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min
50	4	5		

9. Birthplace Summerton, S.C.
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name
13. Birthplace South Carolina

MOTHER
14. Maiden Name Parsons
15. Birthplace South Carolina

16 (a) Informant Odessa O. Hughes
(b) Address 1410 E. Chase Street

17 (a) Burial (b) Date thereof 12/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director CHARLES R. LAW
(b) Address 802 Madison Avenue

19 (a) DEC 2 - 1948 Huntington Williams
(Date filed by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Novemb r 30 1948 11:15 AM

21. I certify that I took charge of the remains described above, held an Ins. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Necrosis of Rt. Hip
Malnutrition

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributed to cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on [illegible] public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 12-1-48

PLEASE WRITE PLAINLY, with ordinary pen and ink. Use no abbreviations. Be correct and complete. Fill every blank. Make no ditto marks. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

669094 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD and town)
(d) Street, No. 524 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WEEMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/28

8. AGE: Years 20 | Months 9 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James T. Weems
13. Birthplace Md.

MOTHER
14. Maiden Name Julia F. Sembly
15. Birthplace Md.

16 (a) Informant Julia F. S. Weems
(b) Address 524 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory Bet. National
Location Baltimore, Md.

18 (a) Funeral director Charles A. Tarr
(b) Address 502 Madison Ave.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Ave. Baltimore Md. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1948; 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds of heart, lungs, liver and stomach.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ☐ primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 2, 1948 Approx. 6:50 P.M.
(b) Where did injury occur? Biddle & Druid Hill
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Hugo G. Wessell M.D.
Medical Examiner

Date signed 12/2/48

PLEASE WRITE PLAINLY with pen and ink. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66,035

66,035

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 day

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 128 N. Belnord Ave. (If rural give location)

(e) Citizen of foreign country? No. Yes or No

If yes, name country

3 (a) FULL NAME Cecelia Sadowski - CECILIA SADOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/18/1871

8. AGE: Years	Months	Days	If less than one day: hr.	min
77	6	14		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Sadowski

13. Birthplace Poland

MOTHER 14. Maiden Name Eva Chodorski

15. Birthplace Poland

16 (a) Informant Agnes Sadowski

(b) Address 128 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 19 . at 10 Yrs AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1948 to 12/1 1948 and that I last saw h[illegible] alive on 12/1 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Arterio sclerotic Cardio - vascular lesion	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Henry V. Chase M

Address Mercy Hospital Date signed 12/1/48

VS 150

669096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

669096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Lansing Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Lansing Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH ANDREW DERNETZ

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-03- 8122

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Catherine
6 (c) If alive, give age 53 years

7. Birth date of deceased mo., day, yr. Dec. 1, 1894

8. AGE: Years	Months	Days	If less than one day
54	0	0	hr / min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Vincent Dernetz
13. Birthplace

MOTHER
14. Maiden Name Josepha peloblaver
15. Birthplace

16 (a) Informant Mrs. Mary C. Dernetz
(b) Address 1706 Lansing Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 1, 1948 at 4.55 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 29 1948 to Dec 1 1948 and that I last saw him alive on Nov 29 1948

Immediate cause of death: Chronic Cystitis
Bacillus infection bed sores
Paraplegia

Due to

Due to Hemorrhage of spinal cord.

Other Conditions

Duration

Date of operation Aug 1946

Major findings of operation:

of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:
(d) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

669097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

669097
Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Entry each item. If unknown or not applicable, so state. Do not leave any space blank. Use additional sheet if necessary. Give full name of city or county hospital. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Aiken St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS JACKSON HORNADAY

3 (b) If veteran, name war: W. W. I

3 (c) Social Security Account No. 216-10-0497

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Marie Ruzicka

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct. 10. 1891

8. AGE: Years: 57 | Months: 1 | Days: 20 | If less than one day: hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Thomas Hornaday
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Not Known
15. Birthplace: North Carolina

16 (a) Informant: Mrs. Rose M. Hornaday (Wife)
(b) Address: 2215 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 3. 1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30. 1948 at 1.00 A.M

21. I certify that death occurred on the date above stated that I attended deceased from Mar 25 47 to Nov 30 48 and that I last saw him alive on Nov 29 48

Immediate cause of death: Coronary Thrombosis — Duration: 11/29/48

Due to: Chronic Myocarditis — 3/.../47

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William J. Rymer M. D.
Address: 801 N. Kenwood Ave. Date signed: 12/1/48

VS 150

66098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. 66098

PLEASE WRITE PLAINLY with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Chilton St., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Harmon Wilkinson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-1296

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Fannie Christine
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 30, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min
60	5	1		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Wire Chief

11. Industry or business: Western Union Telegraph Co.

FATHER
12. Name: Robert W. Wilkinson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Ethel V. Vorsteg
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Fannie C. Wilkinson
(b) Address: 1630 Chilton Street

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 12/4/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Frances Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1, 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/ 1948, to 12/1/ 1948, and that I last saw him alive on 12/1/ 1948.

Immediate cause of death: Bronchopneumonia + Paral Ileus
Due to: Post-Operative complication of Intestinal Obstruction
Due to:
Other Conditions (include pregnancy within 3 months of death)

Duration

Date of operation: 11-24-48
Major findings of operation: Gastro ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: William F. Rodgers, M.D.
Address: 1 Joseph Hospital Date signed: Dec 1, 1948

VS 150

669099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Redwood Hotel, Redwood & Light St. (If rural, give location)
(e) Citizen of foreign country? Yes or No? If yes, name country

3 (a) FULL NAME: ALBERT LEE CRAIG

3 (b) If veteran, name war: W.W.1

3 (c) Social Security Account No. 579-12-07

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1898

8. AGE: Years	Months	Days	If less than one day
50 yrs.	7	14?	hr. min

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name E. M. Craig
13 Birthplace Alabama

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Alabama

16 (a) Informant Mr. Fred. Craig
(b) Address Dade City, Florida

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory Dade City Cemetery
Location Dade City, Florida

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D. (Medical Examiner)

Date signed 12/2/48

Please write plainly, with pen or pencil, and do not use ditto marks. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

86300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No. (illegible)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmond & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Argyle Ave.,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER JACKSON.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased: mo., day, yr. April 1, 1900.
8. AGE: Years 48 | Months 7 | Days 28 | If less than one day: hr. min.
9. Birthplace Frederick, Md.,
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John O. Jackson.
13. Birthplace Calvert Co., Md.,

MOTHER
14. Maiden Name Ellen Stanley
15. Birthplace Md.

16 (a) Informant Elmer Jackson
(b) Address 936 Argyle Ave.,
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 320 N. Schroeder St.
19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1948 at 12 M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948 to 11-27 1948 and that I last saw h/m alive on 11-27 1948.

Immediate cause of death: Cardiac failure — Duration
Due to Arteriosclerotic C.V.
Due to Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address University Hospital Date signed 11-29-48

VS 150

CITY HALL

BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

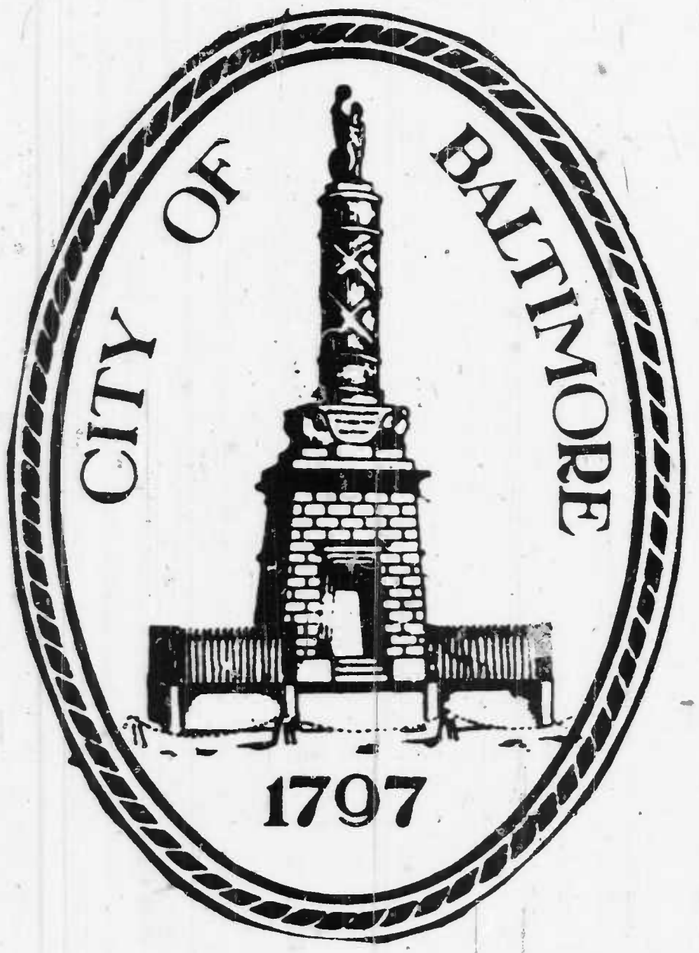
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-9 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 6 274 AND ENDING WITH 69 100 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL